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ABSTRACT

This book is intended for high school and college courses in which personal issues related to addictive problems and substance abuse are a significant focus; the readings and exercises may be of use in teaching such a course as well as helping the student. Chapter 1 provides an introduction to drug and alcohol abuse. It examines recent developments and societal trends, defines prevention, and identifies high-risk groups. Chapter 2 explores both research and theories on drug use. Chapter 3 examines how drugs work, exploring such topics as the chemical transmission of nerve impulses; absorption, distribution, and elimination; tolerance and withdrawal; and drug interactions. Chapter 4 focuses on decision making, examining such issues as attribution, self-efficacy, interpersonal influences, and decision-making skills. Chapter 5 addresses cultural influences on decision making. Chapter 6 focuses on chemical dependence by exploring the disease, behavioral, sociological, and psychological models of dependence. This chapter also examines the development of chemical dependence, the identification of an addicted person, and intervention techniques. Chapter 7 looks at co-dependence; chapter 8 examines recovery, relapse, and non-addictive lifestyles; and chapter 9 considers prevention of addictive problems. Each chapter includes a debate or discussion topic, exercises for further study, and suggested readings. Some chapters also include self-examination topics and a list of recommended films. A resource list and references are appended. (NB)

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# Alternatives

## Choice-making in Daily Life

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# ALTERNATIVES

## In daily life

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*Addiction Studies Institute, University of Detroit Mercy*

## PREFACE

This book represents the accumulated ideas formed during many years of combined effort teaching, delivering clinical services, and organizing prevention programs. It is intended for high school and college courses in which personal issues related to addictive problems and substance abuse are a significant focus; the readings and exercises may be of use in teaching such a course as well as helping the student.

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We want to acknowledge the many students, co-workers and clients who have enriched our understandings of addictive problems.

Thomas W. Blume, Ph.D.
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January, 1993

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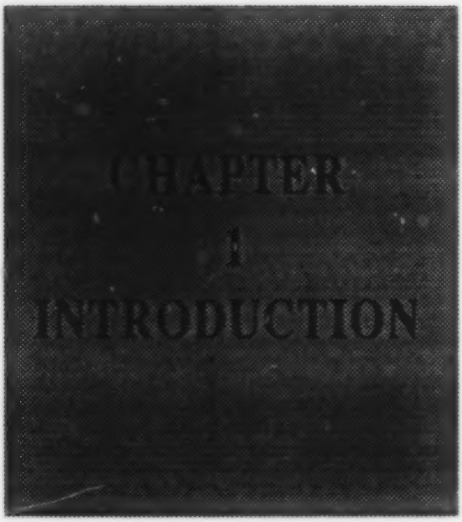


At this time in our nation's history, substance abuse is a subject of great importance to society as well as to the individual. Because of increased public awareness of drug problems, it seems to many people that the drug issue is a new one. However, problems with substances have existed in societies throughout the world as long as historical records have existed.

## Recent developments

The increased interest comes, in part, from changes in the development, distribution, and marketing of mood-altering substances. Laboratories can now custom-design chemicals to have any of a wide range of effects. Some of the "designer drugs" are more powerful in their effects than any which have previously existed.

Additionally, modern transportation methods move drugs from remote laboratories directly to the consumer with little interference, and skillful marketing approaches are attracting younger and younger buyers. The news media focus on criminal activity associated with drugs and their distribution; however, similar problems were also experienced in the United States during the years of prohibition.

A more significant cause of the new visibility of drug problems may be the personal stories of individuals who have "gone public" with their own and their family members' experiences with addiction. Through these individuals, the public has come to understand the extent of health, personal relationship, employment, economic, and societal costs which have resulted from addictions.

## Societal trends

This increasing attention to addictive problems has led to a number of new trends. The first is the increased focus on ***prevention*** of addictive problems among groups who are seen as particularly vulnerable.

College students are one group whose characteristics make them


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especially vulnerable to developing substance abuse problems. The most prominent of those characteristics is the high degree of change in the lives of people who are attending college. For some, change consists of leaving the parental home in early adulthood, experiencing the increased freedom of choice which life in the dorm or in the community offers. For others, change involves exposure to a different circle of friends and different experiences and opportunities (including entry into health services fields which provide access to controlled substances).

Another trend resulting from increased awareness of addictive issues is an increased interest in ***treatment***. Addicts were, until recently, handled in a very punitive way. Modern treatment approaches have focused instead on helping the addict to achieve a substance-free lifestyle. Addiction has been addressed most recently as a holistic health problem which requires, much in the same way as hypertension or diabetes, total change in an individual's lifestyle to achieve a continuing remission of symptoms.

A third trend, one which has gained considerable public and press attention, is a concern with ***reducing or eliminating criminal activity*** associated with distribution and use of illegal addictive substances. Massive efforts to control access to addictive substances have paralleled, in many ways, the unsuccessful effort in the United States to control alcohol during the years of prohibition, the "Roaring Twenties". In the cases of both alcohol and contemporary illegal drugs, the profits from distributing illegal substances have led individuals to take exceptional risks in return for becoming extremely wealthy.

Because of the high level of public interest in alcohol and other drug abuse, this is an especially interesting time to be studying these issues. You may find family and friends extremely interested in the information you are receiving in class. Of course, it is also our hope that the information will be useful in your life.

## What do we mean by prevention?

At the outset, it is important to establish that, as used here, the term ***drug*** refers to any substance which has the ability to alter one's ways of perceiving the world, one's thoughts, and/or one's behavior. As recently as 30 years ago it was being debated whether or not alcohol was a drug; at this time, though, the debate is resolved and alcohol is included whenever we refer to drugs unless it is specifically stated otherwise.

Table 1.1

Partial List of Rock and Roll Performers Who Died of Drug and Alcohol Abuse*

| Name | Group | Date | Cause |
|---|---|---|---|
| Bon Scott | AC/DC | 1979 | Choked on vomit after all-night drinking binge |
| Janis Joplin | Big Brother and the Holding Company | 1970 | Heroin and alcohol |
| Tommy Bolin | Deep Purple | 1976 | Drug overdose |
| Tim Buckley | Solo artist | 1975 | Heroin and morphine |
| Alan Wilson | Canned Heat | 1970 | Drug overdose |
| Jim Morrison | The Doors | 1971 | Alcohol abuse |
| Alan Freed | Disc Jockey | 1965 | Alcohol abuse |
| Ron McKernan | The Grateful Dead | 1973 | Liver disease/alcohol |
| Tim Hardin | Solo artist | 1980 | Heroin |
| Jimi Hendrix | Solo artist | 1970 | Choked on vomit/barbiturate overdose |
| Gary Thain | Uriah Heep | 1976 | Drug overdose |
| Sid Vicious | The Sex Pistols | 1979 | Heroin overdose |
| Dennis Wilson | The Beach Boys | 1984 | Drowned/alcohol |

Others who have had drug/alcohol problems: Grace Slick, Keith Richards, Brian Jones, Boy George and too many others.

* From Harry Avis, Drugs and life. Copyright (c) Wm. C. Brown Publishers, Dubuque, Iowa. All rights reserved. Reprinted by permission.

**DEBATE TOPIC:**
**WHO SHOULD BE PERMITTED TO USE INTOXICANTS?**

The U.S. Government and the states have taken a variety of stands on which citizens should be given access to alcohol. If other drugs were legalized the same kind of decision would have to be made about marijuana, cocaine, or whatever drugs were made available.

As a small group exercise in class or with a few friends out of class, make up two different lists of acceptable and prohibited uses for any particular drug. One list should take the most restrictive stance you can justify, citing issues of public safety, health, behavior problems, etc. The opposing list should take the least restrictive stance you can justify.

The ways in which drugs have their effects are varied and complex; later in this book some of the specific biochemical mechanisms of drug action will be examined in detail. For the moment, however, it is necessary only to recognize that drug use becomes a problem for some people. Most students have had some direct experience; the student, a relative, a neighbor or a close friend has developed a pattern of drug use which led to ***adverse physical, emotional, legal, financial, or relationship consequences***. The outcomes tend to look the same whether the drug use is recreational or it is medically supervised, as is the case with many addictions to Valium, Xanax, and Demerol.

If the reader accepts the idea that some people do develop problems with drugs, it is a short step to further accepting the idea that a society cannot accept and endorse all drug use by all people under all circumstances. Even when some specific drugs have been made available legally, as is the case in this country with alcohol, there have still been restrictions on their use.

In the case of alcohol in the U.S., groups prohibited from using even small amounts include:

- Young people (under 21)
- Prisoners and hospital patients
- Persons engaged in sensitive tasks (e.g. surgeons, pilots)

This kind of restriction is a crude form of prevention; society has determined that the risk of problems is so great for these groups that any alcohol use must be prohibited. The ban on many other drugs-- cocaine, marijuana, and heroin, for instance-- is also a prevention effort. (See summaries of current laws at end of chapter)

But prevention is not always focused on abstinence, that is, avoiding any use of one or more substances. Some prevention activity is focused on responsible use of legal substances. ***Prevention, simply stated, is any effort to keep alcohol and other drug problems from occurring.***

**SELF-EXAMINATION TOPIC: WHAT ARE THE SIGNS OF AN ALCOHOL OR OTHER DRUG PROBLEM?**

A comment heard daily in addiction treatment centers is, "I don't belong here." The typical speaker can cite dozens of criteria for determining who is an alcoholic or addict, such as (1) drinking before noon, (2) drinking "hard liquor" instead of beer, etc., none of which apply to him or her. What would YOU say are the signs that a person has a substance problem?

## High-risk groups

A careful look at the history of alcohol use in contemporary American society suggests that, in addition to the occupational, age, and prison status groups mentioned above, there are other people who deserve special attention because they have shown a high potential for developing drug problems. One group which has recently received extra attention is the elderly population; the combined effects of physical changes, isolation, and over-medicaation with both prescription and over-the-counter drugs seem to lead to especially high rates of drug abuse and addiction among senior citizens.

Another group which has received special notice includes the grown children of addicted parents (COAs). While drug problems are not a certainty for these adults, problems occur with such frequency that the needs of this special group have begun to attract attention. Conditions or background factors such as these, which suggest that a person is especially likely to develop drug problems, are referred to in the prevention field as ***risk factors***, and groups which share risk factors are considered ***high risk groups***. You will be asked in this book to take a

look at yourself, your friends and associates to see who fits into one or more high risk groups; these individuals should use extra caution when handling drugs.

# EXERCISES FOR FURTHER STUDY

1. Interview a professional from one of the following groups or a related occupation:

Clergyperson

Social Worker

Police Officer

Drug Abuse Counselor

Ask your informant what changes he or she has noticed in patterns of alcohol and other drug use, abuse, or addiction since beginning a career. Does he or she feel that drug problems are getting either more serious or less serious?

2. Using microfilm archives, put together a sample of magazine or newspaper articles over a 20-year period. Look at the variations in tone, attitudes, and descriptions of alcohol or other drug-related problems which can be noticed during that period.

# RECOMMENDED FILMS

Some of the issues raised in this chapter are illustrated in popular films. The following are among those which are available on videotape and which may be rented for viewing at home or as a class.

When using a film for this purpose, it may be helpful to ask yourself, "What am I looking for?" Some people find a list helps them to keep their attention focused on concepts, images, and issues which are most important to them.

**I'm Dancing as Fast as I Can**. This film is about a career woman who finds that success comes at high cost to her emotional well-being. Addicted to tranquilizers, hospitalized in mental institutions, she struggles to return to normalcy.

**Sid and Nancy**. Sid Vicious of the Sex Pistols and his partner are the subjects of this semi-documentary about lives on a self-destructive course.

**The Untouchables**. A somewhat glamorized film account of the struggles between the U.S. Government and the alcohol distributors during Prohibition.

**This is Your Life, Jo Jo Dancer**. Sometimes autobiographical, sometimes fictional, this film by comedian Richard Pryor portrays cocaine addiction in the entertainment world.

# SUGGESTED READINGS

You are encouraged to do further reading on some of the issues which were the focus of this chapter. The following suggestions are only a small sample of the books you might find interesting and useful. Full references appear at the end of this book.

The Courage to Change, by Dennis Wholey. This work, based on the author's popular interview show on television, contains personal stories and comments about addiction and recovery from dozens of public figures.

The Times of My Life, by Betty Ford. This book recounts the former First Lady's life experiences, her addiction and subsequent recovery.

# CHAPTER 2
# CHEMICAL USE: HISTORY AND MOTIVATIONS

It appears that there have always been some people who have chosen to use psychoactive substances to modify their behavior and their experiences. The term ***psychoactive substances*** here refers to any substance which, entered into the body, alters thought and/or behavior. Not only the illegal "street" drugs are included; other substances such as coffee, tobacco, and even chocolate have effects which may alter individuals' thoughts and behavior.

Historical and anthropological evidence points to a variety of substances which have been used for their psychoactive properties in different times and places. However, there is no record of any substance which, when used over a period of time, has not been associated with some kind of negative outcome. Beginning in the 19th century, governments around the world began controlling various drugs which were considered especially dangerous.

The United States has seen a wide division between two extreme elements of society. One element has spoken out against all substance use; the other has taken an opposite position, encouraging the random and uncontrolled use of one or more substances. The forces of control achieved a temporary victory in the years 1920 to 1933, during which time the 18th amendment to the U.S Constitution and the Volstead Act eliminated the legal production and distribution of alcoholic beverages. Younger students may have heard stories of prohibition from other family members or may have seen films and television shows depicting these years. Older students may have their own personal memories of these years.

The Prohibition period was characterized by a dramatic rise in alcohol-related crime while only moderate reductions were perceived in rates of drinking or alcoholism. When the 18th amendment to the Constitution was repealed, this action seemed to reflect changs in public attitudes in favor of limited, regulated access to alcohol. This attitude toward alcohol continues, although the only other psychoactive substances currently


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psychoactive substances currently made available for nonmedical use are nicotine and caffeine.

A confusing legal period began with the legitimate manufacture of LSD 25 in the early 1960s. This substance did not fit into existing categories of controlled drugs, and it was temporarily legal for prescribed use. In 1985, in response to a similar problem with the private and uncontrolled production of MDMA (Ecstasy) and other newly created drugs, the U.S. Government adopted a new set of drug control laws which should prevent future problems with the control of "designer drugs."

# A. RESEARCH ON DRUG USE

The U.S. Government has funded a number of studies over the years which have assessed current substance use by adults and young people. It seems unnecessary, at first glance, to conduct research to find out whether or not people are using substances. Obviously there is considerable use, and a brief look around shows that young people are among the most visible users. Visibility, however, is not a fair measure of actual use; those who are most likely to be standing on the street corner, after all, are the individuals who don't have a more worthwhile way to spend their time, and they may be a small minority. Furthermore, many people whose use is more private may be overlooked. For this reason, careful studies are needed to overcome possible misconceptions.

## Levels of use

By far the largest of the U.S. studies is an ongoing study of high school students and college students which is being conducted by Dr. Lloyd Johnston and his associates at the University of Michigan's Institute for Social Research (Johnston, 1991). Working with interview data about current and prior use, they have found only slight differences in overall experience with drugs over the last 15 years, findings which conflict with the public perception of a boom in drug use.

One set of figures showing increases in this period of time, however, is the number of children and adolescents who have tried drugs by a given age. The age of first use has dropped steadily since 1979, with nearly twice as many having used any given drug by the 8th grade; yet the number who end up using alcohol and

same. A second area of change is heavy drinking by college students, which has increased dramatically.

Dr. Johnston and his colleagues have found that use patterns vary widely. While 92% of high school seniors have used alcohol and 61% have used some other illegal drug, the number using monthly or daily is much smaller. About 5% each use alcohol or marijuana on a daily basis, and less than 1% use any other drug daily. Use begins early for some individuals: 10% have used alcohol by the 6th grade. Most drug use is relatively equal between males and females, with the exception of alcohol: daily drinking is reported by 7% of high school senior males and only 3% of females.

The pictures are different for college-bound students and those with no college plans. Those planning to go to college drink less in high school. By their mid-20's, though, the two groups' drinking becomes equal, and college students themselves report more heavy drinking (defined as episodes with more than 5 drinks at one time) than their non-college contemporaries.

## Gateway drugs

Besides Dr. Johnston, other scholars have also looked at ages of use and what is being used. Dr. Denise Kandel and her colleagues at Columbia University (Kandel and Yamaguchi, 1985) have conducted a series of studies of adolescents and young adults, and have concluded that young people in contemporary U.S. society tend to follow a predictable pattern in their use of substances.

Specifically, the pattern they identify as most common is one which begins with alcohol, followed by cigarettes, then followed by marijuana, then going on to other illegal drugs and finally moving on to prescribed drugs. Table 2.1 shows the ages by which 90% ***of those who eventually will become users*** have begun use of a substance. Translating those figures into percentage of the whole sample, including nonusers, they have found almost 20% of children experiencing alcohol by age 10 and nearly 50% drinking by age 14. 99% of their 1980 sample eventually tried alcohol, as opposed to only 80% sampling cigarettes and only 77% trying marijuana.

While this study did not differentiate between college students and other young adults, it does compare with Johnston's findings in that it looked separately at males and

## Trends in Thirty-Day Prevalence of Daily Use for Marijuana, Cocaine, Stimulants, Alcohol, and Cigarettes

Among College Students 1-4 Years Beyond High School

| | Percent who used daily in last thirty days | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1980 | 1981 | 1982 | 1983 | 1984 | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | '89-'90 change |
| Approx. Wtd. N = | (1040) | (1130) | (1150) | (1170) | (1110) | (1080) | (1190) | (1220) | (1310) | (1300) | (1400) | |
| Marijuana | 7.2 | 5.6 | 4.2 | 3.8 | 3.6 | 3.1 | 2.1 | 2.3 | 1.8 | 2.6 | 1.7 | -0.9 |
| Cocaine | 0.2 | 0.0 | 0.3 | 0.1 | 0.4 | 0.1 | 0.1 | 0.1 | 0.1 | 0.0 | 0.0 | 0.0 |
| Stimulants[a] | 0.5 | 0.4 | NA | NA | NA | NA | NA | NA | NA | NA | NA | NA |
| Stimulants, Adjusted[a,b] | NA | NA | 0.3 | 0.2 | 0.2 | 0.0 | 0.1 | 0.1 | 0.0 | 0.0 | 0.0 | 0.0 |
| Alcohol | | | | | | | | | | | | |
| Daily | 6.5 | 5.5 | 6.1 | 6.1 | 6.6 | 5.0 | 4.6 | 6.0 | 4.9 | 4.0 | 3.8 | -0.2 |
| 5+ drinks in a row in last 2 weeks | 43.9 | 43.6 | 44.0 | 43.1 | 45.4 | 44.6 | 45.0 | 42.8 | 43.2 | 41.7 | 41.0 | -0.7 |
| Cigarettes | | | | | | | | | | | | |
| Daily | 18.3 | 17.1 | 16.2 | 15.3 | 14.7 | 14.2 | 12.7 | 13.9 | 12.4 | 12.2 | 12.1 | -0.1 |
| Half-pack or more per day | 12.7 | 11.9 | 10.5 | 9.6 | 10.2 | 9.4 | 8.3 | 8.2 | 7.3 | 6.7 | 8.2 | +1.5 |

NOTES: For all drugs not included here, daily use is below 0.5% in all years. Level of significance of difference between the two most recent years:
s = .05, ss = .01, sss = .001.
NA indicates data not available.

[a]Only drug use which was not under a doctor's orders is included here.

[b]Based on the data from the revised question, which attempts to exclude the inappropriate reporting of non-prescription stimulants.

Table 2.1

Alternatives

females. Like Johnston, Kandel found differences; for instance, girls were more likely to use cigarettes without using alcohol, and boys were more likely to do the opposite. Girls were more likely to go on to marijuana without trying alcohol first, and boys were more likely to go on to marijuana without trying cigarettes first.

One of the implications of Kandel's research is the possibility that certain drugs, because they are accessible and relatively non-threatening, may serve as ***gateway drugs*** through which children and adolescents develop a positive attitude toward drug use. Kandel and others believe that postponing a first experience with a gateway drug can, by delaying entrance into the progression, limit how far through the sequence a person goes. Not trying alcohol or cigarettes until age 18, for instance, should postpone experimentation with marijuana until an age when it is less likely that such an experiment will be attempted.

Following up on this logic, prevention researchers such as Botvin (1985) have shown that programs designed to reduce the use of tobacco by 7th graders can succeed not only in reducing smoking, but also in reducing new and continuing use of alcohol and marijuana.

## Family Characteristics

Finally, looking again at young people as a target group, researchers have examined the social and family characteristics of those individuals who use drugs more than or less than their peers. Among the more recent findings, Baumrind (1991), in a longitudinal study which followed children from the age of 4 through the age of 15, found that those who developed into adolescent non-users more often had "authoritative parents who are highly demanding and highly responsive." She noted that families which relied solely on firm control had less drug use, but their children's drug use was more serious if it did happen.

Coombs and Landsverk (1988), comparing a number of current characteristics in a large sample of children from two-parent families ranging in age from 9 to 17, found the ***father's*** role to be especially important in determining substance abuse. They summarized their data as showing that, in abstainers' families, "both parents play an active role in providing counsel and advice, setting limits, and offering trusting and encouraging relationships."

Table 2.2

Age by Which 90% of Users of Each Drug Have Been Initiated Into the Drug

| Drug | Age | Total Users |
|---|---|---|
| Alcohol | 18 | (1,305) |
| Cigarettes | 19 | (1,049) |
| Marijuana | 20 | (955) |
| Psychedelics | 21 | (335) |
| Cocaine | 24 | (392) |
| Minor Tranquilizers - Own use | 23 | (216) |
| Sedatives - Own use | 23 | (245) |
| Minor Tranquilizers - Prescribed use | 24 | (311) |
| Sedatives - Prescribed use | 23 | (100) |

Source: Kandel and Yamaguchi (1985). Used by permission.

## B. THEORIES OF DRUG USE

Making sense of the descriptive information above would be easier if we could agree on why people use drugs. There are many theories, however; in fact, the authors of this book assume that everyone has a theory of substance abuse even if he or she is unable to state it.

One way of checking out people's theories about substance use involves asking the users themselves. This was done as part of a treatment program for adolescents at Texas Tech University (Blume, Green, Joanning, & Quinn, 1985. The adolescents' theories about their own use were surprisingly similar to theories which are discussed by the experts in the field. The reasons these adolescents gave tended to fall into two categories:

One category of reasons described their decisions to use a substance which they had not previously used. This kind of decision, which will be discussed in this chapter, may be characterized as ***experimentation*** or

***exploration***. We will look at a few selected theories -- both some academic ones and some "street level theories" regarding substance use, beginning with those which attempt to explain individuals' motivations for having a ***first experience*** with drugs.

Another category of reasons described their decisions to ***repeat*** a previous drug-induced experience. This kind of decision fell into further subdivisions of occasional use, regular use, abuse, and addiction. Discussion of these decisions will wait for a later chapter.

The reader will notice that the term, "decision" has been used in reference to substance use. This is, of course, contrary to the way in which most people describe their behavior. Actually, the question of whether or not people are able to control their own substance use is a very complex issue, one which is a continuing theme throughout this book. For the moment, however, it is worth noting that addicts seem to <u>feel</u> a lack of control. One goal of this textbook is to clarify how much choice people have in substance use (and in other aspects of life as well).

## Peer Influence.

Probably the most widely-cited theory, one which is at an intuitive level understood by almost every adult in our society, is that of ***peer pressure***. The peer pressure theory, stated simply, predicts that "individuals will use drugs when there is clear and

**DISCUSSION TOPIC: WHICH CAME FIRST, THE MENTAL DISORDER OR THE ADDICTION?**

Medically-oriented researchers and treatment professionals have often been heard expressing their belief that addicts' disordered behavior is a result of the drug use. Psychologists, on the other hand, have often said that they felt an addiction was a symptom of an underlying mental disorder such as depression.

More and more, treatment facilities are seeing the "dual diagnosis" case which involves both the signs of addiction and the signs of a mental disorder. How might researchers go about trying to determine which came first? Does it matter?

persistent pressure from an important group of peers." Most people seem to imagine a group of 13-year-olds, all using drugs, surrounding a younger or same-aged individual who is being told "try it--you'll like it!"

But a theory of peer influence may take several more complex forms. One form would consist of a ***social learning*** (Bandura, 1977) discussion of the tendency for people to copy others who have been rewarded for their behavior. This theory explains drug taking by youth who see entertainers or sports stars, for example, using substances and living a personally fulfilling and professionally rewarding lifestyle.

A new, and hopefully more complete version of a peer influence theory is the ***Social Role Negotiation*** model (Blume, 1991). This approach incorporates information about the particular life stage of the individual and his or her developmental capacity for individual choice. According to this theory, people are especially likely to use substances to cope with a high level of stress during periods of rapid personal change

The goals of substance use, according to this theory, are of two kinds. The first goals more symbolic, involves the ***statement*** made by the use. Membership in a peer group may be instantly achieved by taking the proper substance. The second, more physical, goal is ***relief*** from the emotional and cognitive effects of stressful experiences that the adolescent may have. Drugs may not only medicate the symptoms of negative interactions with parents, peers, teachers, and others, but may also improve those interactions by compensating for individual

**SELF-EXAMINATION TOPIC:**
**ARE YOU ATTRACTED TO DANGER & "FORBIDDEN PLEASURES ?"**

The dangers of alcohol use, according to some observers, are part of its attractiveness. Some experts claim to see concealed danger images, including the skull and crossbones, in magazine ads for alcohol products.

Thrill-seeking seems to be a lifestyle. For people who are prone to get involved in dangerous activities, it is especially important to learn how to assess the difference between real danger and simulated danger. There are some kinds of thrill which have little risk of death or disaster. Others, though, present the possibility of AIDS, permanent disability, and addiction. Are you a thrill-seeker?

personality characteristics which prove dysfunctional. For example, an adolescent who considers himself or herself to be shy, reserved, and emotionally inaccessible may be more outgoing and therefore more accepted by others while under the influence of alcohol.

## Drives.

A totally different kind of theory is held by those who propose that human beings have an innate, or built-in, drive which leads to the use of substances. This kind of theory, which suggests that drug taking is inevitable, seems valid because of historical evidence that drug taking is common in all historical periods and cultures.

The first of these theories proposes that people seem drawn toward thrills and excitement. Drug-taking provides a thrill to some extent because of its illegality. The chemical effects of some drugs, furthermore, serve to directly stimulate the same parts of the brain which are involved in high-risk activities such as sky-diving. Even alcohol, which is legal for adults 21 and over and which physiologically serves not as a stimulant but as a depressant, can fit this model because of its image of danger.

An alternative theory which uses the idea of a drive is the psychoanalytic theory of ***libido***. Freud believed that a pleasure drive called libido was basic to human nature, and that the pleasure drive could be satisfied in many ways. Drug use often provides a kind of pleasure, especially in the early stages before unpleasant effects become part of the experience. It also is related, in many cases, to other pleasant experiences -- sucking, swallowing, inhaling and exhaling -- which may provide the libido with satisfaction.

Some scholars of drug-taking have proposed an additional kind of drive, a drive toward ***transcendence*** (see, for example, Norman Zinberg's Alternative States of Consciousness). According to these theorists, drug-taking along with religion and other human activities all strive toward a common goal of altering experience. They say that what is nearly universal among humans is not drug use, per se, but the pursuit of altered states through means such as religious meditation, fasting, dancing and exercise as well as through substance use.

## Compensation

The final group of first-use theories suggests that some people are more likely to use drugs than others.

This approach supposes some special characteristic which "needs" the drug to compensate and allow these individuals to function normally.

Two of these theories have existed for years. The first, a psychoanalytic view, assumes that people experience stress from internal conflicts between their natural tendencies and the way they have been taught to behave. When such internal conflict exists, according to this theory, people are prone to look for a way of reducing the stress. Drug-taking, then, would be one of the ways the individual attempts to achieve a normal feeling of peace and relaxation when internal conflicts are too great.

The second of the traditional compensation theories attributes stress to a different source. This view of drug use points to the unnatural stresses which lifestyle can place on the individual. Among the groups of people vulnerable to compensatory drug use might be the inner-city poor; successful individuals in stressful professions such as law and medicine; and heavy laborers (the coca-leaf chewing natives of Peru and Columbia are often cited). College students of any age might be considered such a high-risk group. Drug use would, again, be one of the alternatives which might be tried as a way of relieving the stress.

**DISCUSSION TOPIC: AN INTRIGUING THEORY, "SELF-HANDICAPPING"**

A rarely-mentioned approach to substance use, the Self-Handicapping Model (Berglas & Jones, 1978), states that some people use alcohol or other drugs to protect themselves from the possible consequences of failure; they can say, "I know I could have done better if it hadn't been for that hangover." This concept would, of course, apply most to very competitive people who are fearful that they can't meet their own or others' expectations in school, recreation, relationship, or work settings.

If this conceptualization is correct, a particularly vulnerable population might be college students. Students are in a situation where they are constantly being evaluated, and some students are likely to feel that they have gone beyond their own abilities, that they are destined to fail at their current coursework or their eventual career choice.

Do people in such a situation have some other options besides "shooting themselves in the foot?"

A new, more sophisticated set of compensation theories has been proposed in recent years, looking at the possibility that some individuals' ***brain chemistry*** may be slightly out of balance. For instance, if a person were too calm and too placid, he or she would then require higher levels of stimulation in order to bring experience to a level of intensity matching what other people experience as normal.

Finally, another kind of theory focuses on the possibility that substance users are responding to problems in their home, work, or community environments. This theory, which sees the maladaptive use of drugs as a symptom of a larger ***system*** problem, is particularly compelling when applied to individuals whose behavior prior to the drug use did not indicate any other problem.

From this perspective television news personalities, politicians, sports figures, and television stars who have entered into self destructive, substance using lifestyles may be seen as essentially healthy people. Their negative behavior was attributable to forces outside themselves and beyond their control.

## Summary

This discussion has presented several ideas about people's reasons for initiating and continuing drug use; some may have been quite like your own ideas, others may have felt strange. None has been proved to be the only correct explanation, and it may be that several are correct at the same time.

In the end, though, what one believes about drugs seems to shape how one responds to them. Most people's beliefs are constantly changing as they assimilate new information and test their theories. The following chapters will provide what will prove to be, for many readers, some new information, and will examine the various other sources of information and opinion which are part of your decision-making process.

# EXERCISES FOR FURTHER STUDY

1. Interview friends and relatives about their substance use experience (or lack of it) and the reasons they identify for having made the choices they have made.

2. Locate the film, Hooked: The Psychology of Intoxication, produced by Hazelden Foundation in Minnesota. This film is owned by many local health departments, public libraries, and drug treatment facilities and may be available at no cost. The film may be most enjoyable if watched as a group with friends who are also concerned with drugs.

The following questions may help to stimulate discussion following the film (there are no right or wrong answers):

-- Are you able to relate to the notion of a human need to experience an altered state of consciousness?

-- Have you ever experienced a wondrous sense of fulfillment after hearing a certain musical piece, viewing a painting, or simply staring in awe at the beauty of nature?

-- Did it seem to you, prior to viewing this video, that "intoxication" can occur without the use of substances?

# RECOMMENDED FILMS

Some of the issues raised in this chapter are illustrated in popular films. The following are among those which are available on videotape and which may be rented for viewing at home or as a class.

When using a film for this purpose, it may be helpful to ask yourself, "What am I looking for?" Some people find a list helps them to keep their attention focused on concepts, images, and issues which are most important to them.

**Altered States**. This film portrays a researcher who gets carried away with his investigations. While it does not pretend to be scientific, the film raises questions about the potentials of as-yet undiscovered drugs.

**Clean and Sober**. Widely heralded by the recovery community at the time of its release, this film demonstrates the struggle for a quality recovery.

**The Mind -- Episode 4, Addictions**. This episode from the widely distributed PBS television series puts some questions about consciousness and drug effects into a useful form.

# SUGGESTED READINGS

You are encouraged to do further reading on some of the issues which were the focus of this chapter. The following suggestions are only a small sample of the books you might find interesting and useful. Full references appear at the end of this book.

Alternate States of Consciousness: Multiple Perspectives on the Study of Consciousness, edited by Norman Zinberg. Chapters written by a variety of authors illustrate and critique the idea that consciousness-changing is the goal of drug use.

Craving for Ecstasy: The Consciousness and Chemistry of Escape, by Harvey Milkman and Stanley Sunderworth. This book proposes a model for differentiating among drug users according to their preferred drugs.

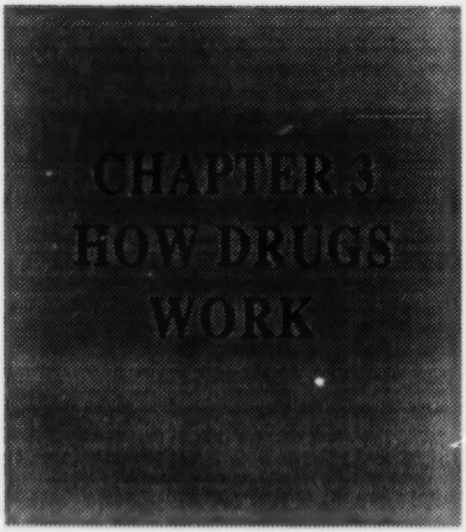
Drinking in America, by Mark Lender and James Martin. Employing a historical perspective to examine the apparent ambivalence of Americans concerning alcohol, the authors look at the groups who have helped develop a new public consciousness about the consequences of abusing alcohol.

Dual Diagnosis, by Evans and Sullivan. This introductory book for students and professionals provides an overview of approaches to working with those who manifest both a chemical dependence and a psychiatric disorder.

Social Thought on Alcoholism: A Comprehensive Review, edited by Thomas D. Watts. A collection of articles reflecting changes in both the nature of alcoholism and thought about the phenomenon.

The Natural History of Alcoholism, by George Vaillant. This dramatic research report follows a cohort of men from early alcoholism into a variety of outcomes including recovery, death from complications of drinking, and apparent spontaneous recovery.

Theories on Drug Abuse: Selected Contemporary Perspectives, edited by Lettieri, Sayers, and Pearson. A U.S. Government publication available in most college and university libraries, this exhaustive review of theories demonstrates activity in many different academic fields.




Most people, it seems, are familiar with the effects of alcohol and other depressant drugs which inhibit activity in the central nervous system. Their picture of a drug addict is one of a lethargic, dazed, uncoordinated, pathetic person. Imagine the shock when, as in recent years, the U.S. population began to deal with large numbers of people whose addiction was to a stimulant. This addict was not lethargic; instead, the addict was the top producer in the office, the one who had one or two additional jobs, the liveliest, most dynamic person in the group.

One of the most recent drug trends has been the preference for stimulants such as cocaine and "ice", a smokeable variant of methamphetamine. These drugs not only provide a feeling of confidence and invincibility, they also suppress appetite and subject the nervous system to a constant level of overstimulation. The addict gradually becomes more emotionally and physically fragile and displays poor judgment and mood swings.

Drug effects are quite complicated, and most people do not have very much knowledge about the substances which they use and those which are being used around them. In some cases seemingly harmless substances can be very dangerous. In other cases substance use which starts off being manageable and which seems problem-free can develop into a dangerous dependence or a harmful pattern or abuse. Knowledge alone does not prevent abuse -- if it did, doctors, dentists, nurses, and pharmacists would not have problems with addiction -- but knowledge may help you to recognize dangerous behavior in yourself and others.



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# A. CHEMICAL TRANSMISSION OF NERVE IMPULSES

The brain and other parts of the nervous system work in a manner which seems very indirect and cumbersome. The nerve cells, called neurons, which make up the system do not touch each other, and nerve signals are not directly passed from one cell to the next. Rather, the signals pass in a chain reaction from cell to cell through the use of chemical messengers. These chemicals, known as ***neurotransmitters***, work either together or in opposition to each other to selectively pass on signals. There appear to be over twenty neurotransmitters which interact in different combinations (Cohen, 1989).

It may be helpful, in discussing this process, to have a mental image. If you think of a squirrel jumping from the branches of one tree to the branches of the next, this could be one molecule of a neurotransmitter. But this is a relay race; before a squirrel can jump, it has to be tagged by at least, let's say, five other squirrels arriving from other trees. Weak signals, trees which only send one or two squirrels out, will not result in a response which gets passed on. Meanwhile, competing signals are being passed by owls, who will eat up the squirrels if there are enough of them. If there is a strong signal, then, and no strong competing signal, the message continues through the system.

What all drugs do -- although the ways in which they do it can be different - is to somehow alter the process of passing messages through the nervous system. You should be familiar with a few common ways in which drugs do this:

First, they can ***increase the output*** of some chemicals, or act as substitutes for them. Depending on the chemicals (squirrels or owls?), this could make their signals stronger or block more of the competing signals.

Second, they can ***decrease the output*** of some chemicals, or chemically destroy them. This would reduce the strength of their signals and could allow others to get through more easily.

Third, they can ***block the receptor sites*** for the chemicals. In this case, no matter how strong the signal it would not get passed on.

Finally, they can interfere with a process called ***reuptake***. This process recycles excess molecules, ones which are not absorbed by neighboring neurons. Through the recycling of these molecules they are taken out of

action, thereby keeping them from continuing the signal when it's no longer appropriate. Furthermore, the recycled chemicals conserve the nutrients which are the building blocks needed for making more neurotransmitters. Interfering with this process, then, has the dual effects of extending the effect of some signals and depleting the nutritional stores of the brain.

This brief explanation should make a convincing case for the idea that you need to know what drug you are talking about when you want to predict how "taking drugs" could affect someone. And, as explained below, expert advice can be needed to evaluate the likely results of combining different street drugs and prescription drugs. When drugs are combined their effects may add together, or they may multiply -- making one or another dangerously strong or they may counteract each other -- blocking a much-needed therapeutic effect. If you have concerns about drug effects you should consult a pharmacist, a doctor, or other source of accurate drug information.

## B. ABSORPTION, DISTRIBUTION, AND ELIMINATION

Various physical processes alter the effects of a particular drug or combination of drugs. As a result of these processes, one can overdose on the same amount of a drug which has been repeatedly used in the past.

The first of these processes is the ***absorption*** of the drug into the body. Depending on the way in which the drug is introduced it may take effect immediately or very slowly. Generally speaking, the faster the reaction the more likely the individual will feel a compulsion to repeat the experience. Smoking and intravenous injection are the fastest modes of use; pills are among the slowest. Alcohol, though it is taken in through the stomach like pills, is absorbed more rapidly because it passes directly through the walls of the stomach.

Once the drug is in the body, it must be transformed into a useable form and reach areas where it will be active. For many substances this ***distribution*** process is time-consuming. Cocaine in its standard form, for example, requires one change; for

other drugs as many as two or three separate chemical changes may need to take place before the active form is produced. Because drugs such as alcohol and the crack form of cocaine enter the body in an active form, they produce a more rapid effect.

Finally, the body must accomplish the ***elimination*** of every drug which comes in. Just as in the case of distribution, this may require several chemical steps, and the process can be disrupted both by large amounts and multiple substances.

The organ which breaks down complex substances into easily eliminated ***metabolites*** is the liver. Normal liver processing can be inhibited, though, by too great a load imposed by drug use. Alcohol, for instance, places a great strain on the liver. An overloaded liver creates many problems. As the liver has the task of preparing substances for distribution, needed food and drugs may be prevented from being appropriately used by the body. Delays in preparing drugs for elimination can then leave toxic metabolites circulating in the system for days at a time. And damaged liver cells may die, blocking the flow of blood.

Some substances present a special problem when it comes time to eliminate them from the body and attempt a return to normal functioning. These substances attach themselves to blood cells in a process called ***protein binding*** or they remain stored in fat cells. Small amounts may then be released for a long period of time after drug use has ceased. Some of the active ingredients in marijuana act this way, a finding which raises questions about how long a person must be abstinent from marijuana to be considered drug-free.

## C. TOLERANCE AND WITHDRAWAL

Finally, as we catalog the physical effects of drugs on the body it is necessary to introduce the concept of ***physical dependence*** of the body to repeated use of substances. This phenomenon, which we generally refer to as ***addiction***, is actually quite complicated and occurs in various forms with different substances. The process begins with the development of ***tolerance***.

An individual develops tolerance to most drugs with repeated use; the individual requires, over time, larger and larger doses to achieve a desired effect. Tolerance occurs because the

**DISCUSSION TOPIC:**
**INVOLUNTARY DRUG TESTING IN THE WORKPLACE**

Many governmental as well as private employers have chosen in recent years to begin programs of mandatory urine testing of their employees for the presence of drugs.

For some groups of employees the issue of public safety has been cited as justification. Passenger train engineers are one such group. Employers of some other groups, though, justify the decision on the basis of preventing serious medical problems.

Critics suggest that the motivation seems to be more strictly economic and that fundamental rights to privacy are being violated. they also raise questions about the possibility of inaccurate procedures wrongly identifying someone as a drug user.

How would you respond if you were asked to provide your employer with a urine sample? What if you were asked to collect a sample from one of your most trusted and valued employees?

human body is a very adaptive organism; it is capable of adapting its ways of functioning to accept the presence of a variety of substances, and furthermore is able to function in a normal manner despite their presence.

The effectiveness of the body's adaptive mechanisms is so great that the user may experience frustration, as the amount of a drug which formerly created a "high" no longer achieves that effect. Nearly all substances are capable of creating some tolerance in the human body. In fact, many substances taken by prescription or for recreational purposes create a kind of ***cross tolerance*** -- the use of one creates a tolerance for the use of others.

When the body has adapted to the presence of a new substance, the removal of that substance from the individual's system creates a second response known as ***withdrawal***.. Withdrawal reactions range from the mild discomfort of an alcohol hangover to the extreme life-threatening symptoms (such as

seizure) which may result from withdrawing larger amounts of alcohol. Contrary to popular belief, a hangover doesn't prove that one is not alcoholic; instead, it's a sign that the body is making progress with the task of adapting to alcohol.

As the processes of tolerance and withdrawal interact in the pattern known as addiction, tolerance increases and creates a need for the substance in order to maintain normal functioning. When any less than a given amount is present in the body, withdrawal symptoms appear. Taking more of the substance, of course, only temporarily postpones withdrawal symptoms and further quantities are soon required.

## D. DRUG INTERACTIONS

Among the most challenging issues facing doctors and pharmacists is that of drug interactions. The discussion above can help you to understand why it can be very dangerous to mix drugs. Drugs can interact because they ***counteract*** each others' effects, or they can interact because they either ***add*** or ***multiply*** their similar effects. All these possibilities can be deadly.

When drugs counteract each others' effects, a larger amount of each is required to have the same effect. Of course, this increases the strain on the liver and may lead to slow processing and the presence of toxic by-products. But raising the amount needed for one effect may not raise the amount required for other effects. The lethal dose, that which will halt brain or heart activity, often stays the same. Therefore the amount needed to get "high" gets closer and closer to the amount which will kill.

When effects are similar they may merely add in a predictable way or they may multiply and produce unpredictably stronger effects. Overdoses can occur, then, from combining the safe doses of two drugs or even from cutting the dose of each in half and combining them. Many people, not thinking of alcohol as a drug, experience overdoses because they ignored alcohol's ability to increase other drugs' effects.

The more drugs one is taking, prescription and over-the-counter drugs alike, the more likely it is that something will produce a negative interaction. The safest course of action is to make sure that a trusted pharmacist or physician is aware of all drugs, including alcohol, you are taking. He or she can then warn you about possible interactions.

# EXERCISES FOR FURTHER STUDY

Individually or together with friends, use some of the drug references in your school or community library to gather information on the characteristics of:

a. the drugs which are in your medicine chest(s),

b. any prescription or over-the-counter drug you think is being taken by family members or friends.

c. drugs you have heard mentioned in connection with either addiction or suicide attempts.

Your reference librarian can direct you to the variety of resources (including, in many libraries, computer databases) which may contribute up-to-date findings; reference works more than a few years old should not be considered valid.

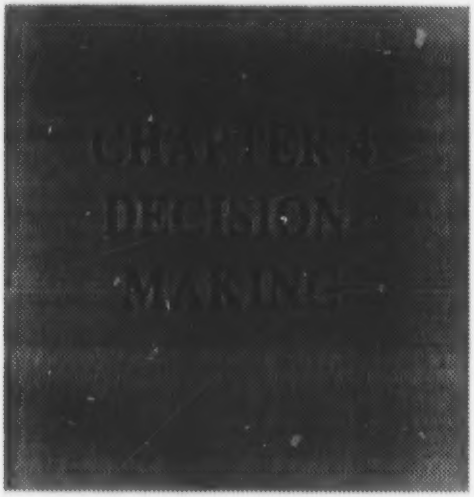
# SUGGESTED READINGS

You are encouraged to do further reading on some of the issues which were the focus of this chapter. The following suggestions are only a small sample of the books you might find interesting and useful. Full references appear at the end of this book.

Physician's Desk Reference (updated yearly). Frequently available in used bookstores as well as in most libraries, this is the basic reference work for learning about dosage, side effects, interactions, and contraindications.

The Chemical Mind, by Sidney Cohen. A brief and powerful summary of research and theory about neurotransmission, its role in mental activity, and drugs.

The Pharmacological Basis of Therapeutics, by Goodman and Gilman. After repeated updatings, this continues to be a basic text in nursing courses; it not only describes individual drugs, it provides authoritative explanations of drug actions.



Decision-making takes place any time a person chooses to have a particular thought, or to behave in a certain way, when other alternatives are possible. It is not a skill which everyone masters. The times when decisions apparently must be made are times of stress for many people, and people who handle dramatic, difficult decisions with ease -- judges, executives, legislators -- are given positions of exceptional power and privilege. But decisions are not always dramatic, and people often are not aware of their decision-making processes.

Decisions can be observed very early in human life. Babies show a preference, if given a choice, for viewing objects which resemble a face. When they are old enough to crawl, they choose to stop crawling when they approach what appears to be a cliff. As children become older, they make more and more choices. Their awareness of making decisions develops gradually, along with their ability to consider how to make a decision. Fortunately, many kinds of decisions can be reversed or changed on the basis of new data or newly developed decision-making abilities. Decisions to use a particular substance, for example, are generally reversible when the use is still experimental.

Possibly the most studied aspect of decision-making, and certainly the most important for drug abuse prevention, is ***moral decision-making***. Lawrence Kohlberg (1969) and other researchers have interviewed adults, adolescents, and children about their ways of deciding what behavior is acceptable. Young children tend to see moral decisions as fairly simple, determined by the punishment for wrongdoing. Acts which are punished more severely are more unacceptable, and getting away with something makes it acceptable.

As children enter elementary school they come to understand the social need for rules and laws, and concern themselves more with gaining approval and making a positive contribution to society. Older children and adolescents tend to be extremely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idealistic. Finally, some adolescents and adults demonstrate even more complex decision-making processes in which every rule is examined for its appropriateness and no rule is considered absolute.

These findings fit together with other information about the ways in which children and adults develop new ways of thinking. Decision-making of all kinds is affected by the developing ability to analyze, interpret, and organize experiences. Aternatives can only be fully considered when future events can be anticipated, and such thinking is often not developed until mid-adolescence. And other people's viewpoints and needs are not easily considered; only with years of practice are children able to "put themselves in someone else's shoes" as a way of making decisions.

Many other intellectual traditions besides Kohlberg's cognitive developmental approach have examined decision-making; these will be examined in the rest of this chapter. First, social psychology will provide ways of understanding societal and personal influences on decisions. Next, the chemical dependence field will contribute understandings of the similarities among all dependent behavior patterns. Finally, communications studies and behavioral psychology will provide understanding of the skills needed for better handling of decision-making opportunities.

# A. THE SOCIAL PSYCHOLOGY OF DECISION MAKING

One way of looking at a person's decision-making processes is to look at how those processes fit into the ***interpersonal environment*** -- the other people who are, and have been, a part of his or her life. Social psychologists have studied several aspects of human interaction which play a role in decisions.

## Attribution

The first of these involves people's ***understandings*** of the things which happen to them; these are referred to as ***attributions***. Attributions are the product of an interaction between the self and others, and are subject to change. An example will illustrate:

*Mrs. Brown opened the door to get the morning paper and it wasn't in its accustomed spot. After looking around the porch, she felt sure that the paper was not merely misplaced; it wasn't there. Which of the following thoughts is most likely? (a) I must have not paid the carrier; (b) The carrier skipped me. You can't trust anyone to do a job right anymore; (c) The carrier skipped me. It wouldn't have happened if I weren't old and poor; or (d) Someone stole my paper. How cheap can you get?*

All these are attributions; Mrs. Brown is attributing the situation to one or another cause. Generally, people attribute events either to themselves or to some other person(s). People tend to follow patterns in their attributions, and some of these patterns cause specific problems when it comes to decision-making.

A particularly well-known attributional pattern is known as ***locus of control***. If Mrs. Brown's locus of control is internal, she will most likely attribute the missing paper to herself rather than to someone else; the concern about missing a payment would be likely. If her locus of control is external, she is more likely to place responsibility for the event outside herself.

In the case of the paper, an internal locus of control is not the only reasonable option; the other possibilities deserve consideration. In other situations, though, such as getting a parking ticket for parking in a restricted zone, an internal locus of control is entirely appropriate. Blaming the ticket on the police officer's bad mood or on the positions of the stars would most likely be an error. Neither a totally internal nor a totally external locus of control is always going to be appropriate.

## Self-efficacy

A second social psychological factor which influences decision-making is that of self-efficacy (Bandura, 1977). Like other components of the self-concept, this is a product of both the person's experience (e.g., spilling a glass of milk) and what others say about the experience (e.g., "You're clumsy.") If an individual believes that he or she is able to handle the demands of a particular challenge, the challenge will be seen positively. On the other hand, if he or she feels incapable, the challenge will seem negative and may be avoided.

## Interpersonal influence

People's decisions are affected by others, sometimes intentionally and sometimes unintentionally. Social psychologists have made an extensive

study of ways in which people influence each other. Their studies have examined such things as advertising, propaganda, persuasion, threat, and bribery.

All influence processes fall into one of two categories. The first seeks to make a change in person's behavior at the moment. This can be done without changing the person's beliefs about the behavior ("You can make me do it, but you can't make me like it.") The second is more subtle; it involves changing the person's opinions or beliefs so that the behavior appears to be acceptable. The two processes overlap to some extent; people have been found to change their beliefs after the fact to justify something they have already done.

How do influence attempts relate to attributions? People who tend to attribute events in their lives to others -- those with an external locus of control -- are especially easy to influence. As they don't feel responsible for their behavior, they are willing to do almost anything since it can always be blamed on someone else ("She made me do it.") One key to resisting influence is to shift one's locus of control toward an internal direction, taking responsibility for one's acts and accepting blame when it is appropriate.

Self-efficacy also plays a vital role in the interpersonal influence process. People who feel confident that they can take a stand are likely to do so. "Just say NO" is a reasonable expectation for someone who has said "no" before and has felt successful at saying it. It is unreasonable to expect this kind of strong behavior from someone who feels unable to make any demands on other people. It is possible, however, for such a person to develop the ability to resist influence attempts. First he or she must learn the necessary skills and develop confidence in handling differences with others.

Both attribution problems and self-efficacy problems are common among children, adolescents, and adults who have been living in situations in which they felt powerless and may have been victims of physically or emotionally abusive behavior. Within poverty subcultures where people live with prejudice, limited opportunity, violence and self-destructive behavior, there may be little group support for developing the belief that one is a capable, self-directed individual who can make a difference in the world.

## B. DEPENDENCE AS A LIFE-STYLE

The study of addictions to alcohol and other drugs, as well as other compulsive behavior, has in recent years begun to organize around a central principle of ***dependence*** (see, for example, Peele & Brodsky, 1972). This dependence involves abandoning personal responsibility while seeking solutions to problems in the outside world. The common element in these dependent patterns is a lack of energy directed toward appropriate goals. At the same time, though, a dependent behavior such as cocaine addiction may be very time-consuming and may demand high levels of energy.

The dependent person develops a life-style in which substances, activities, or other people appear to eliminate decision-making; the decisions are already made, and the dependent person just does what is "necessary." It takes a high degree of skill, sometimes, to arrange for someone else to start the argument which will result in retreating to a drink. Similarly, it isn't always easy to find someone whose self-destructive behavior will provide an excuse for ignoring one's own needs (this pattern of co-dependence will be addressed in Chapter 7). But the dependent person develops the necessary skills.

External locus of control and low self-efficacy may be assumed to exist even before the initial contact with the addictive substance, person, or behavior. The accumulated experiences which build dependence include attempts at control over the behavior, followed by loss of control and the resulting shame, humiliation, and erosion of self-efficacy. These experiences tend to reduce people's already impaired decision-making abilities. Recovery from a dependence, therefore, is especially difficult without some outside support for making the decision to get help. Because of this handicap in handling decisions, the addictions field has come to rely on the policy of only making decisions "one day at a time."

The popular press as well as the professional literature is full of stories of people who were helped in making the decision to end a dependence; who completed a period of treatment in which they demonstrated their ability to survive without the addictive behavior; and yet somehow returned to the dependence. This pattern, usually known as relapse, appears to follow the same sequence described above: the dependent person is able to find a person, substance, or event on which to place the blame for returning to the self-destructive behavior.

**DISCUSSION TOPIC: DECISION BY INDECISION**

Students of logic are familiar with a technique some people use to fool themselves about their decision-making. The technique is very simple; it merely requires putting off a decision until external events force the decision to go one way or the other. For instance, if you can't choose between the hamburgers and the hot dogs at a cook-out, you would wait until everyone has been served ahead of you. By then it is likely that one or the other will be gone, and then there will be no difficulty deciding.

Have you known people who handle decision-making this way? Do they often manage to end up getting what they really wanted anyway, but without having to take responsibility if they end up not liking it? What could be wrong with this approach?

# C. THE SKILLS OF EFFECTIVE DECISION-MAKING

Decision-making is a skill like throwing a ball. When it is done well it is effective and it takes minimal effort. When it is done badly, the amount of effort expended is not worth the outcome. And just as a poorly thrown ball can break windows, the outcome is often unfortunate.

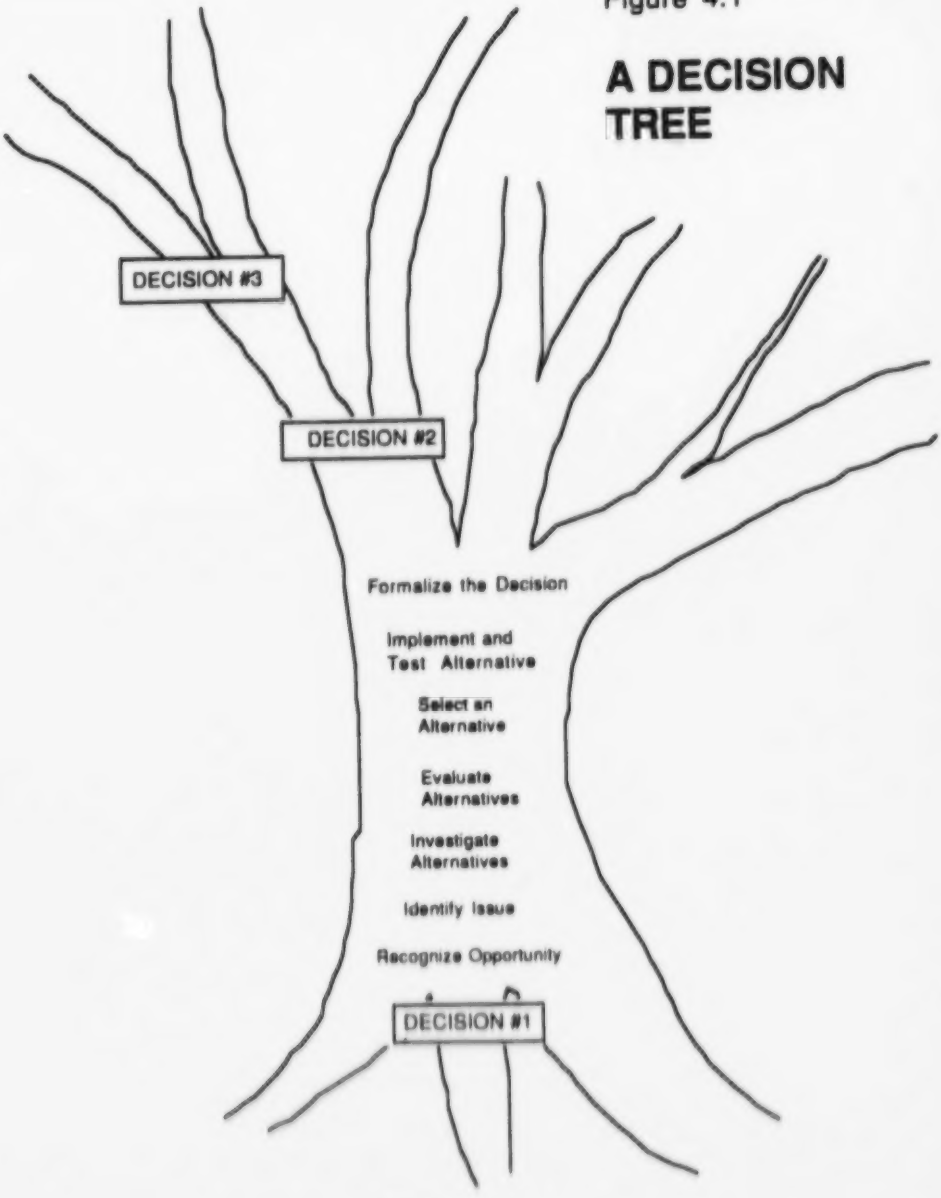
There are at least three basic levels of decision-making: decisions on one's own, decisions which must be made in collaboration with another person, and decisions which must be made in a larger group. Fortunately, the three levels can be seen as operating in similar ways.

The steps of good decision-making are simple and can be mastered by children by the time they leave elementary school. But all the steps must be taken each time a decision-making opportunity arises. The steps can be visualized as being part of a decision tree (Figure4.1).

As the first step, at the bottom of the tree, decision-makers must ***recog-***

Figure 4.1

## A DECISION TREE



***nize that a decision is about to be made***. Many people live their lives as if on automatic pilot, following the course of least resistance and never pausing to think of alternatives. A careful look at a typical day will show dozens, if not hundreds or thousands of decisions being made. Getting out of bed requires a decision. Brushing teeth, eating breakfast, etc. require decisions. The question to use for identifying a decision opportunity is, "Would it be possible to do something differently from the way I expect to do it?" If a different action is possible -- even if it is apparently undesirable -- a decision is being made.

Second, decision-makers must ***identify the issue being decided***. Frequently problems present themselves as only having two choices, and the issue may appear to be "pretzels or potato chips." In such situations a more careful analysis may find a broader issue, such as "I'm hungry." Then a more careful decision process can follow. This step is one which is more difficult if the decision is a shared one; people frequently disagree about what the issue is, and they cannot hope to come to a satisfactory solution until they have a shared goal. Often a single decision can be broken down into a series of smaller decisions, and it may be easier to take them one at a time rather than consider them all.

Third, decision-makers must ***investigate the alternatives*** which present themselves. This step is more complicated, because the ways of doing this are somewhat complex. As stated above, the most obvious alternatives are the first ones to come to mind, and others may not immediately be apparent. Creative problem solvers have found two solutions to the shortage of alternatives. They either brainstorm -- generate a list of ideas which may seem crazy, but which won't even be evaluated until all are written down -- or take a more logical approach and let the issue sit for a day or two. Either approach taps into thought processes deep in the brain which aren't immediately accessible. This step, especially when more than one person is involved, can be exciting.

Fourth, decision-makers must ***evaluate the alternatives***. It is assumed that most people seek to minimize the costs (not only financial costs, but also fatigue and pain) and maximize their gains; this is known as the minimax solution to a problem. The amount of information on all the alternatives, however, may be overwhelming.

When the alternatives are few, it may be possible to examine all equally. But when there are many alternatives, it is normal to use some kind of search strategy in looking at

choices. For instance, when looking at colleges to attend it would be possible to limit the search to those which offer a degree in physical therapy; those in Michigan which offer a degree in physical therapy; or all those with campus drug prevention programs.

Many decisions are weakened at this step by inadequate searches as well as by reliance on faulty information. If the decision on colleges is to be made based on the college catalogs found in the public library, for example, the collection may be incomplete or there may be new programs on some campuses which were not completely formed at the time the catalog was printed. A more complete search would involve starting with a guidebook or index, then gathering literature from the most promising schools and eventually speaking on the telephone or visiting in person with a faculty member in the desired program. At the worst extreme, decisions are sometimes made from memory when people could have verified the information and eliminated serious errors.

Fifth, decision-makers must ***select one of the alternatives*** (or a mix of several). This selection may be according to a set of selection rules such as a point system which gives every alternative points for different areas of strength and weakness. If a clear rule cannot be applied, the decision has to be made either by chance (e.g., flip of the coin) or on a more intuitive (gut, or feeling) basis. Researchers have found that some people get too hasty at this step, making a choice before their evaluation is complete. Oliveri and Reiss (1981) found that some families, playing a game in the research laboratory, would choose an obviously poor alternative just to get the waiting over with.

Sixth, once a decision has been made decision-makers must ***implement and test the decision***. An apparently good decision can turn out to be unworkable when applied to reality; when time permits, any decision should be field-tested in a small way before a total commitment is made.

Finally (seventh), it is very helpful if it is possible (particularly when more than one person is involved) to ***formalize the decision*** with a ceremony or a document. For example, people who decide to quit smoking have been known to throw a partially smoked carton of cigarettes into the trash as proof to themselves and others that they are serious.

After step 7, if a series of decisions are being made, the process repeats itself with a return to the beginning step, moving up the tree with the next decision.

# EXERCISES FOR FURTHER STUDY

1. A staggering number of decisions can be made in a short span of time. Many of our decisions are at a non-conscious level and they are noticed only with considerable effort.

a. Try working independently to monitor your actions, thoughts, attention to details, and memory processes. For example, you might try to be aware for 30 seconds of all the coordinated muscle contractions you have been responsible for.

b. Following an independent effort, try the same task working with a partner to find out if either of you sees the other one doing things which may be done without awareness.

2. You may go through several decision steps without realizing it. People whose behavior gets them into trouble frequently say, "it just happened," when in fact they set up a situation where their actions were almost inevitable/

Try to recall an incident when your actions brought disapproval, punishment, or other negative consequences. As you look back at such an event, can you see how your earlier decisions led in the direction of whatever finally became a problem?

# RECOMMENDED FILMS

Some of the issues raised in this chapter are illustrated in popular films. The following are among those which are available on videotape and which may be rented for viewing at home or as a class.

When using a film for this purpose, it may be helpful to ask yourself, "What am I looking for?" Some people find a list helps them to keep their attention focused on concepts, images, and issues which are most important to them.

**Awakenings.** This portrayal of author and psychiatrist Oliver Sachs shows his decision process as he decided to use an experimental drug on chronic mental patients.

**Sex, Lies, and Videotape**. A different view of decision-making, this film focuses on several characters each of whom seems totally unaware of decisions and their consequences.

**Sophie's Choice**. An illustration of decision-making at an incredibly painful level, this film also portrays the agony which can be the aftermath of making decisions.

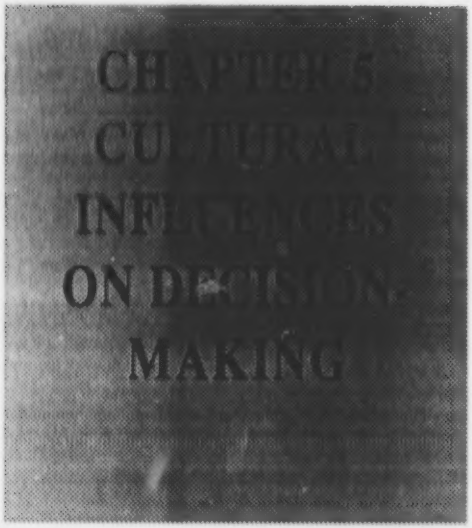
**Stand by Me**. This film about early adolescence and curiosity demonstrates group process in decision-making, as a group of boys go in search of an accident victim's body.

# SUGGESTED READINGS

You are encouraged to do further reading on some of the issues which were the focus of this chapter. The following suggestions are only a small sample of the books you might find interesting and useful. Full references appear at the end of this book.

Choicemaking, by Sharon Wegscheider-Cruse. Most widely recognized for her work with children of alcoholics, the author outlines options available to those struggling with family and other relationship issues.

Choices and Changes, by Lorne Tepperman and Angela Djao, considers how we make choices to reach the goal of life satisfaction. It poses the question, "Who is most satisfied, under what conditions, and why?"




Throughout the world, contemporary societies are in rapid transition. Problems the U.S. is facing now, including high levels of drug-related crime, an escalating national debt, apparent corruption in private and public institutions, homelessness, and environmental deterioration, are similar to ones being confronted in many other societies. Even totalitarian regimes, which held deviant behavior in check for generations, have lost their ability to control their citizens.

Paradoxically, when people feel a loss of control within their society they seem to respond with greater efforts to achieve personal power and control. And one particular kind of attempt at controlling life -- through drugs, both prescription drugs and other legal and illegal substances -- is especially popular because of its short-term effectiveness (See Table 5.1, "Most Frequently Used Drugs"). This tendency is unfortunate because it also has a reverse effect, over time, of worsening the quality of life for many individuals.

This chapter will look at culture -- the beliefs, values and lifestyles of different groups of people. We will review evidence that cultural factors seem to increase or decrease the risk of becoming addicted as they influence decision-making processes related to drug use. We will also propose that people can do something about the ways in which they are affected by cultural factors, thereby resisting current negative forces and also ending patterns of behavior which may have persisted for many generations.

## A. THE INDIVIDUAL VS. THE GROUP APPROACH

Until recently the best-known theories of substance use focused primarily on the individual's decisions and behavior. People who abused

alcohol and other drugs were considered to be weak, self-destructive, or impulsive individuals. But current writings on the abuse of alcohol and other drugs show a gradual shift in emphasis from the effects of individual psychology to the influence of environmental factors on drug use. At the same time, treatment efforts have also begun to focus more on the family and the workplace as essential elements in recovery.

The power of environmental influences has been recognized among prevention professionals for a long time. With a few exceptions such as summer camps and weekend retreats, prevention does not lend itself to an approach which involves taking people out of their routine and giving them an intense experience which is expected to change their lives. And when people's lives are examined in detail, family relationships, peer expectations, economic circumstances, and cultural heritage appear to be formidable influences.

## Family relationships

Family relationships are a complex web of influences. Among the strongest substance-related patterns of cultural influence are those which involve age and sex roles. Certain kinds of behavior are expected based on age and gender, and most people conform to expectations. In some families, for instance, substance abuse is expected among young adult males; in others, the absence of substance problems is an essential part of appropriate behavior. But expectations of family and others -- sociologists refer to these expectations as ***roles*** -- can be dangerous even when they do not encourage substance use; many women, for example, develop serious alcohol problems because they have been so effective at hiding their drinking from family members and society.

## Peer expectations

As mentioned above, the peer environment has been the major exception to the societal focus on individual responsibility. Particularly among adolescents, peers have been blamed for pressuring each other to use. And there have definitely been peer groups in which one "had to," according to the group's members, drink or use other drugs. Theories such as Bandura's (1977) Social Learning Theory, however, are beginning to explain how some individuals are more strongly influenced than others by such expectations. Furthermore, social influences don't occur one at a time; even though the peer group is important, it is only one of many places people receive information about how to behave. Finally, Peer Cluster Theory (Oetting & Beauvais, 1986) has elegantly described the way

Table 5.1
Most Frequently Used Drugs

| Product | Rank in 1986 | Rank in 1985 |
|---|---|---|
| Dyazide[1] | 1 | 1 |
| Lanoxin[1] | 2 | 2 |
| Amoxil[2] | 3 | 6 |
| Tylenol with codeine[3] | 4 | 5 |
| Tagamet[4] | 5 | 7 |
| Xanax[5] | 6 | 15 |
| Inderal[1] | 7 | 3 |
| Lasix[1] | 8 | 8 |
| Motrin[3] | 9 | 10 |
| Tenormin[1] | 10 | 13 |
| Valium[5] | 11 | 4 |
| Keflex[2] | 12 | 11 |
| Naprosyn[3] | 13 | 14 |
| Darvocet[3] | 14 | 9 |
| Premarin[6] | 15 | 12 |

The superscripts refer to the purpose for which the drugs are taken: (1) for heart conditions such as high blood pressure; (2) antibiotics; (3) pain killesr; (4) for ulcers; (5) antianxiety drugs; (6) estrogen replacement. Notice that twelve of the fifteen most commonly prescribed drugs are medications related to psychosomatic conditions such as pain or stress, high blood pressure, ulcers, and anxiety.

Source: National Institute of Drug Abuse, 1987. Used by permission.

in which people may choose a group whose influence they want.

### Economic circumstances

Poverty and unemployment play a major role in many people's abuse of substances, a role often ignored by those who have been fortunate enough to have escaped these societal ills. Instead of empathizing with the stresses of limited opportunity, financially secure members of society often take the impoverished substance abuser as proof that abuse represents "free-loading", lack of motivation, and hedonism. People generally tend to attribute others' behavior (but not their own) to individual choice; they see themselves as only responding to circumstances. This is a universal error noted by social psychologists Jones and Nisbett (1972). In the case of the poor, the tendency to "blame the victim" may also serve societal needs if, as some experts suggest, a free market society must sacrifice certain segments of its population.

### Cultural heritage.

When high rates of substance abuse are noted within a society it can be inferred that the drug problem is an integral part of the society. In examining contemporary U.S. society from this perspective, Edwards & Arif (1980), suggest that several factors be examined: (1) How much importance is placed on the individual as contrasted with allegiance to governing authorities? (2) What types of deviance are permitted? (3) Does the society allow each ethnic group to foster its own cultural heritage? (4) Can a "melting pot" society such as the one that exists in the U.S. incorporate the differing attitudes, customs, beliefs and goals of many different groups? In fact, some cultural groups have dramatically different rates of substance problems.

## B. THE "QUICK FIX" CULTURE

In contemporary U.S. culture, children are indoctrinated from their earliest experiences in the belief that one need not experience any kind of discomfort. Modern medicine, for example, promises instant relief from a vast majority of minor ailments and

from many serious illnesses as well. Doctors give shots to fight an infection and pills to suppress a headache or other uncomfortable symptoms, and some recommend massive doses of vitamins (pills) to ward off potentially threatening illnesses.

Of course, there are many valuable, positive uses of drugs in medical practice. But for many patients drug taking has become a normal life event. The idea that one might practice preventive medicine through sound nutrition, exercise, self knowledge and awareness of genetic factors has given way to the "quick fix." As one anonymous physician said, "It takes 30 seconds to write a prescription and 30 minutes not to."

There are strong parallels between such negative health-related attitudes and addictive behavior; both demonstrate the pursuit of immediate gratification, self deception, and feeling of control while exhibiting powerlessness. Addictions take away anxiety and prevent people from becoming aware that maybe "everything isn't OK." Addicts stop having faith in their own knowledge and feelings and turn to something or someone else to tell them if they are right or wrong.

Stephen Covey (1989), in his book, The Seven Habits of Highly Effective People, contends that prior to 1939 the basis for success in the U.S. was adherence to a character ethic. This included traits such as integrity, humility, fidelity, temperance, courage, justice, patience, industry, simplicity, modesty and the Golden Rule. He cites Benjamin Franklin as an example of attempting to live by these tenets, or principles. Since 1939, Covey says, this ethic has been replaced by a personality ethic. Covey describes this change:

*Success became more a function of personality, of public image, of attitudes and behaviors, skills and techniques, that lubricate the process of human interaction. This personality ethic essentially took two parts; one was human and public relations technique, and the other was positive mental attitude.*

In recent years, lending support to Covey's analysis, the market has been flooded with books on topics such as the power of intimidation and how to dress to convey power. The self help books of the past 20 years are full of promise; but the realistic reader knows that easy personality change, weight loss, instant wealth, and a perfect mate are desperate illusions perpetuated by an impatient society.

For both the affluent, "successful" individuals who succeed in manipulating the system, and those deprived of meaningful ways to "succeed", the result is the same: they

seek ways to alleviate the intense discomfort that accompanies both striving and its dualistic opposite -- deprivation of opportunity. Alcohol and other drugs become a viable means of coping.

**DISCUSSION TOPIC: ARE YOU PART OF THE SOLUTION OR PART OF THE PROBLEM?**

Modern medicine has arrived at a position which asserts that some conditions must be allowed to correct themselves; viruses, for instance, are resistant to all but the most dangerous drugs. But doctors report that patients won't settle for being told that there's nothing to be done for a pain or ailment; they want a drug. Some doctors make a practice of prescribing something, just to avoid an argument.

Which are you more likely to do:

-- Question the doctor as to why a prescription is necessary?

-- Question the doctor as to why you aren't getting a prescription?

# C. ETHNICITY AND CULTURAL VALUES

Drug dependence has often been seen as closely identified with cultural identity. But this link has tended to be seen only as a problem, rather than as having positive implications. For instance, policy makers and program administrators have often overlooked helpful, positive cultural factors such as values.

## Changing cultures.

Some experts believe that the change in the use of drugs is most dramatic where ***rapid socioeconomic change*** has taken place. The following examples, based on materials published by the World Health Organization in its Public Health Papers series (Edwards & Arif, 1980), seem to illustrate the "protective" power of traditional values and the consequences of their loss.

a. Northern Thailand hill tribes smoke opium for pleasure, even in front of their children; women also smoke, but they do it privately because it is less acceptable. (In the U.S. a strong stigma still exists against women who use drugs

excessively. Drug abuse by males is not condoned, but is viewed with less recrimination than that exhibited toward women.) Opium is also used widely as medicine in villages where medical care is lacking. In the slums of Thai cities, however, adolescents inhale or inject heroin as a response to urban stress, as do some young people in the United States.

b. For centuries, villagers in the Andes have chewed coca leaves. They use it to relieve thirst and hunger while cutting sugar cane, as a medicine, for gregarious or social purposes, and for mystical insight. In cities surrounding the Andes villages, however, the much more potent form of coca paste is smoked, leading to addictive problems and destructive lifestyles.

## Minority cultures.

Because of the relationship between poverty and some kinds of drug use, a better understanding of minority cultures may help in developing strategies for change. Peter Bell (1987), studying the apparent failure of many treatment efforts directed toward the black community, contends that this failure is due to reliance on data taken from the white middle class counseling establishment. He believes that much of the literature has projected, or transferred, these findings onto the black community, but it has not been a good fit.

Bell believes that it is necessary to know oneself in order to reject drugs as a coping method. He states that abandonment of cultural norms, and subsequent attempts at assimilation or acculturation (that is, accepting the values of the dominant white community) leads to susceptibility to drug abuse.

## High - and low- risk groups.

Observers have noted that alcoholism is not equally distributed around the world. In some cultures, alcoholism is not a major problem; others, however, seem to have a high rate of alcohol problems. The cultures with low rates are especially intriguing because they may point to ways in which other groups' problems may be reduced.

The Italian culture is one frequently studied group. Alcohol use is commonplace in Italy, and alcohol is served with most meals, even to children. Drinking alcohol is an acceptable cultural behavior. There is no confusion about its place in people's lives and consequently there is little need to use it for reasons other than family and social discourse. The same kind of expectation seems to operate within traditional Jewish

cultures, which also have an extraordinarily low incidence of alcoholism.

Groups which have especially high rates of alcoholism also may point the way for prevention programs. Among one of the most commonly discussed groups, the Irish, it seems that the cultural history attributes almost magical power to alcohol. Especially in families where nearly every adult for generations has been alcoholic, it is easy to see how people could believe that "the first drink wiml lead directly to alcoholism" Among the Irish it is not unusual to find adults who took a non-drinking pledge early in their lives and credit that pledge with having saved their lives.

Total abstinence from alcohol is more common, in fact, among cultures and within families where alcoholism is widespread. It appears that the same fear of alcohol leads both to extreme avoidant behavior and to addiction. Theorists looking at this pattern explain that it is the special status given to alcohol which apparently creates the alcoholism. It is worth noting, however, that some interpret the same findings to be supportive of the idea that alcoholism is genetically transmitted unless people abstain totally.

## D. MEDIA INFLUENCES

Advertising is another cultural factor which has a major impact on the decision-making processes of individuals. Huge sums of money are spent to convey the message that one can feel good by ingesting substances; the advertising budget of the beverage alcohol industry in the U.S. is approximately 2 billion dollars per year! Other drugs, too, are glamorized on television, in films, and in print.

The dollars available to counter these powerful, expensively produced messages cannot begin to compete with the amounts spent on advertising. Some people even contend that advertisers use advanced technology to produce subliminal (out of conscious awareness) messages promoting use. Regardless of the tactics used, when prevention programs recommend healthy, self-affirming lifestyles their recommendations are challenged by messages promoting use of alcohol and other drugs.

Increased public awareness may begin to counteract the persuasive influence of advertising. For instance, in a pair of 1989 news stories cigarette and alcohol advertisers were criticized widely for their efforts which targeted two different groups -- young, working-class women and black men -

- with new products which were designed to be consistent with the buying habits of these groups. When, as in these cases, legal restrictions fail to prevent such abuses, public outcry may be the best restraint mechanism available.

In addition to advertisers, news media have also been highly criticized by prevention specialists. The media have often contributed to misunderstanding by featuring only the most sensational drug and alcohol-related news. Meanwhile individuals whose work requires public exposure, such as those in entertainment, politics and sports, have had their lives scrutinized by millions of people. The line between "a right to know" and exploitation of human adversity has become confused and blurred. Such publicity has been justified by the statement that it is the media's role to inform, and that it is a role that has been assigned by society.

Attempting to take advantage of this power, in recent years citizen groups and public agencies have sponsored anti-drug and anti-alcohol public service announcements which send messages about alternatives to use. Additionally, a few popular films have portrayed, in graphic form, the futility and hopelessness around drug abuse. It seems that through such positive media efforts, public awareness is increasing.

# EXERCISES FOR FURTHER STUDY

1. Organize a small group in any way you please; it may be more interesting if you do not try to control the composition of the group. Then attempt to find at least one aspect of your cultural backgrounds which is shared by every member of the group. You may find that it is not one of the most immediately obvious cultural influences.

2. Conduct a small research project within your extended family, the faculty in your department, or your neighborhood. If you ask people about their experience knowing or living with an alcoholic, how many female alcoholics do you readily get information about? Asking family members, you will most likely hear of very few; likewise, alcoholism treatment facilities have traditionally had few women referred as patients. Why might we be reluctant to identify the women alcoholics in our families?

# RECOMMENDED FILMS

Some of the issues raised in this chapter are illustrated in popular films. The following are among those which are available on videotape and which may be rented for viewing at home or as a class.

When using a film for this purpose, it may be helpful to ask yourself, "What am I looking for?" Some people find a list helps them to keep their attention focused on concepts, images, and issues which are most important to them.

**Drugstore Cowboy.** The outlaw society of addicts stealing and dealing to support their lifestyle is portrayed in this story, which has a surprise ending.

**Lady Sings the Blues**. This film depicting the story of singer Billy Holiday's success as a blues and jazz singer during the 1920s recounts, in detail, her descent into the world of heroin use and, eventually, her death.

**My Left Foot**. This inspiring story of triumph over a physical handicap offers a glimpse into the multigenerational pattern of alcoholism in a working-class Irish community.

# SUGGESTED READINGS

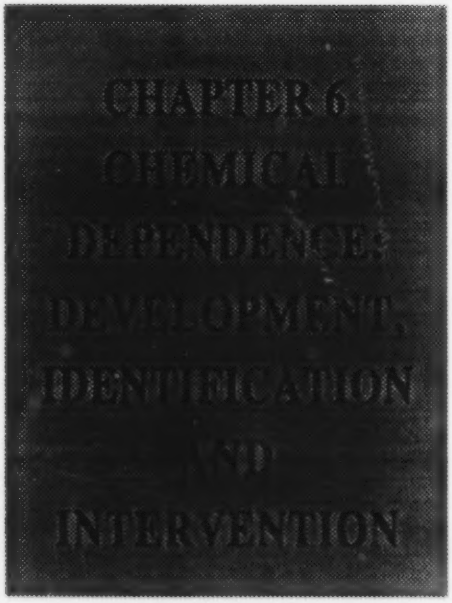
You are encouraged to do further reading on some of the issues which were the focus of this chapter. The following suggestions are only a small sample of the books you might find interesting and useful. Full references appear at the end of this book.

Ethnicity and Family Therapy, by Monica McGoldrick, John K. Pearce, and Joseph Giordano. This professionals' reference book provides summaries and discussions of what is considered problem behavior within different cultures.

Positive Addictions, by William Glasser. Glasser, author of Reality Therapy, suggests that in a society which promotes addiction mental health may be achieved by arranging to become addicted to things which not only provide immediate rewards but also have long-term value.

The Addicted Society: Pleasure-Seeking and Punishment Revisited, by Joel Fort. Dr. Fort suggests that our cultural history in the U.S. leaves us vulnerable to addictions, and proposes a complete reorganization of society to overcome this tendency.

The Dependency Tendency, by Jay P. and Julia M. Gurian, proposes that individuals need to be dependent as well as independent. The authors cite examples of society's directives to avoid dependency.




Among the difficulties faced when talking about substance abuse problems is the question of chemical dependence or addiction (for reasons we will try to make clear, we will use the terms interchangeably). The essential issue, from many people's perspective, has to do with whether or not the substance abuser still has a *choice* about his or her behavior. Since the drug user's behavior may cause problems for society, choosing to punish or to treat the individual will depend to a great extent on everyone's conclusions: was this voluntary or not?

In the typical scenario, the user says "I can't help it" while family members say, "She can stop for weeks at a time, but she keeps starting again. She's just looking for trouble." This chapter will address this conflict by looking at what is known about chemical dependence and how that information can help friends, relatives, and professional helpers to respond in meaningful ways when they believe a problem exists.

## A. VIEWS OF CHEMICAL DEPENDENCE.

There is little agreement within either the research or the treatment community as to the causes, prevention, or treatment of substance abuse. While there are many different theories, none is totally accepted. The following perspectives are often in opposition to each other.

### Disease models

In the 1950s the World Health Organization (WHO) responded to a growing movement by recognizing alcoholism as a "disease." Many people saw this event as a significant move forward for addiction treatment, offering the opportunity to eliminate the "self-indulgent" and

"irresponsible" labels which were often attached to those with alcohol problems. "If alcoholism is a disease," their reasoning went, "an individual can't be punished for displaying its symptoms."

For some of the people who supported this definition of alcoholism, in fact, it was more a political act than a medical/scientific finding. But in the decades since this declaration, the view of alcoholism as a disease has become the dominant position among treatment professionals and self-help group members even though there is little agreement about diagnostic criteria and/or understandings of the physiological processes of addiction. The "triad of addiction" identified in the WHO definition are the three generally accepted elements of the disease conceptualization: (1) ***physical dependence***, which was described above; (2) ***psychological dependence***, which will be addressed later in this chapter; and (3) ***tolerance***, which was also described in an earlier chapter. E.M. Jellinek, whose work profoundly shaped thinking in the field, added (4) an apparent ***loss of control*** over drinking, as well as (5) ***progressive health deterioration***.

Alcoholics Anonymous (AA) was among the groups which called for the designation of alcoholism as a disease. While AA began as a pragmatic, results-oriented program which didn't depend heavily on theory, members of the group tend to agree on a particular kind of disease theory. This position starts with the observation that when several people drink the same amounts of alcohol over the same period, only a certain percentage will become addicted. Therefore, according to the AA belief, the alcoholic's ***physical makeup*** must be different. This is popularly understood as an inherited predisposition toward addiction which some characterize as an allergic response.

There is research support for such an idea. Dr. Henri Begleiter (1979), a psychiatry professor at the State University of New York Health Center, studied young sons of alcoholic fathers and found that 35% of the sons had brain wave patterns similar to those of alcoholic individuals. Since none of the children were reported to have ever had a drink, Begleiter concluded that traits predisposing the sons to alcoholism may be inherited.

In the 1970s Jerome Jaffee proposed a further redefinition of the disease after his involvement with men who had served in the Vietnam War. He suggested that an addiction is "Compulsive use, characterized by an overwhelming involvement with the use of a drug and securing its supply, . and manifesting a strong

relapse tendency." David Smith, founder of the San Francisco Haight-Ashbury Clinic, proposed yet another revised definition, one which has been instrumental in shaping recent developments in psychiatric diagnosis: "Compulsive use with loss of control and ***continued use in spite of adverse consequences***." Note that these interpretations differed from previous definitions in that they omitted any mention of physical dependence and tolerance.

## Behavioral models

Herbert Fingarette (1986), professor of philosophy at the University of California, maintains that alcoholism is not a disease but is merely a "central activity to a person's way of life". He believes that drinking, as it continues beyond the normal level, becomes a preoccupation; the drinker makes a decision to continue to drink, and has the ability to control the amount. This approach emphasizes the series of decisions, judgments and choices that comprise the excessive drinking syndrome.

Generally speaking, behaviorists strongly reject any relationship between physiological factors and excessive drinking and propose the concept of ***reinforcement***, both positive and negative, as a primary cause for continued heavy drinking. Reinforcement is anything that increases or decreases the likelihood of the drinking occurring in the future. Social approval (positive reinforcement) and the reduction of anxiety over continued drinking (negative reinforcement) are two examples.

## Sociological models

Sociological models exist as well; these conceptualizations shift the focus away from the individual to the society. Watts (1986) differentiates between two sociological perspectives in viewing alcoholism: (1. The ***strain*** perspective defines it as a form of deviant behavior. That is, the established norms for drinking in the community are exceeded. (2. The ***labeling*** perspective attributes power to the alcoholism label assigned by others. The person being labeled, according to these theorists, is selected from the total population of heavy drinkers less because of the drinking itself than because of social standing, including factors such as sex, age, social class, race and mode of dress.

Another sociological model, exemplified by the work of Steinglass and his associates (1989), examines ***family adaptation*** to and perpetuation of destructive drinking patterns. In some family models, such as that of Wegscheider-Cruse (1981), specific

familial roles are anticipated as a result of the conditions children and spouses experience while living with an active alcohol abuser. These models challenge the genetic factor explanation; when excessive use of alcohol is traced through the family, say these theorists, the behavior may have been transmitted through parenting patterns and the interpersonal dynamics that resulted from these behaviors.

## Psychological models

The existence of an ***underlying personality disorder*** is another, frequently cited explanation for addiction (this position was discussed above -- see the "Which Came First" discussion topic in Chapter 2). In one intrapsychic (inside the mind) model, unconscious unresolved childhood conflict is seen as manifested in the drinking behavior of the adult. Fixation -- being stuck at an early stage of development -- is identified as the cause of current behavior. But more widely accepted at this time are models which cite shame, guilt, alienation and dependency as the factors which underlie dysfunctional human behavior. These factors may be intertwined in people's choices, including addiction to things, people or feelings. In Chapter 8 these issues will be addressed as lifestyle elements which are subject to change.

Finally, the continued use of substances of all kinds (as well as compulsive behavior of other kinds) may be explained in terms of ***psychological dependence***. Many people have known someone who appeared to have little or no control regarding such behavior as watching television, shopping, or gambling. These activities are probably self-perpetuating not because of their direct chemical effect on the body, as can be claimed for substance use, but for some other reason. The key ingredient in a psychological dependence seems to be the individual's belief that he or she is incapable of controlling the behavior or will suffer unbearable discomfort if the behavior is stopped. In many cases the psychologically dependent individual does not automatically suffer immediate physical withdrawal symptoms upon stopping the substance use or the compulsive behavior. Physical symptoms may, however, result from beliefs, as occurs when a placebo creases a drug-like effect without any chemical action.

# B. REASONS FOR IDENTIFYING CHEMICAL DEPENDENCE

Treatment professionals have argued for years over whether or not accurate assessment of the chemically dependent individual is possible, as well as over whether or not assessment is necessary. This long-standing debate over diagnosis, as discussed below, seems to be resolved to some extent by a recently proposed model which focuses on matching problems with resources but doesn't incorporate the concept of disease.

## The medical approach

The medical tradition teaches that a particular disease entity will respond to treatment only when, once a proper diagnosis has been made, the most effective treatment for that particular disease is provided. Progress in treating hundreds of diseases over the last few generations has come from rigorous application of this principle; this is what distinguishes modern medicine from historical periods in which every disease was treated with rest, fresh air, and mineral waters (or other generic health-improvement approaches).

Proponents of this approach to chemical dependence believe that alcoholism and other addictions are unique diseases which must be treated in disease-specific ways. They believe that an alcoholic can be accurately distinguished from someone whose drinking is problematic but non alcoholic, and that the two should be handled differently. As an example of this approach, the Diagnostic and Statistical Manual for Mental Disorders, Third Edition-Re vised (DSM IIIR) includes descriptions of both alcohol abuse and alcohol dependence, with criteria for diagnosing one or the other. Once a clinician has gathered the appropriate data, he or she should be able to compare the data with the criteria and classify the case. A treatment approach matching the problem would then be planned.

In recent years the strong believers in disease conceptualizations of alcoholism and other drug problems have been joined by those who see many individuals as dually diagnosed: suffering simultaneously from a substance abuse disorder and another mental disorder such as depression or mania. They believe that misdiagnosing either the substance problem or the co-existing mental problem will lead to incorrect treatment and will delay or prevent recovery.

## Behavioral approaches

Other treatment professionals disagree on both the need for, and the potential for, accuracy in identifying a substance problem. They point to data which indicate that many individuals who could have been diagnosed as alcoholic change their drinking patterns without either professional help or involvement in a self-help group; this, they say, indicates that there was no disease. Furthermore, authors such as Stanton Peele (1989) call attention to the low levels of agreement among diagnosticians. This lack of agreement suggests to them that there is not a clearly defined disease.

From this perspective, drug problems and other problems in living are simply behavioral patterns which need to be changed. What is needed, they believe, is not to label the problem but to accurately describe the behavior which needs to be changed. Good data collection is still critical, but what gets done with the data is different. Instead of allowing the therapist to classify the problem, the data become a baseline which provides a standard against which progress will be measured. Behaviorally oriented treatment programs pride themselves on being able to specify how much they have changed the patient's or client's behavior.

Whereas disease model proponents believe that the nature of the treatment should be different based on the diagnosis, behaviorists believe that the necessary treatment is essentially the same regardless of the kind of problem. Assigning an individual to one or another level of treatment intensity, for instance inpatient as opposed to outpatient, would be done on the basis of treatment history, that is, what has been tried so far, and level of risk should the use continue.

## The "funnel" approach.

Despite their contradictions of each other's positions, these two seemingly opposite traditions agree that an individual with a self-destructive pattern of substance use needs help. Furthermore, they both believe that detailed information about the individual's problem is helpful in planning for treatment.

The recently published book Broadening the base of treatment for alcohol problems, a comprehensive review of the alcohol treatment field sponsored by the National Academy of Sciences (1990), offers a moderate position which may resolve the debate to some extent. This study focuses on the shortage of appropriate treatment facilities and suggests that resources can be extended further if intensive treatment facilities are not used except

when necessary. The authors propose seeing substance problems as a funnel, with large numbers of people at the wider end with mild problems; smaller numbers with more serious problems; and a small group at the narrow end whose problems have reached the point where intensive treatment is needed.

This model, then, supports the need for assessment, and agrees with friends, families, and co-workers who want help with getting treatment for an individual who has some kind of problem. Where the NAS study takes the most dramatic turn from long-standing traditions is in its recommendation that those at the wider end of the funnel should be identified right away rather than waiting until later. This change, the authors recognize, would require that a much broader group than only the addiction professionals get involved in calling attention to possible problems. There are two advantages if this were to be done. First, problems should respond to earlier intervention; fewer people should go on to advanced problems. Second, overall success rates of treatment should improve because the advanced stages of addiction are so difficult to treat. The addiction professional's role, then, would be to help determine when a more intensive level of help is needed.

## C. DENIAL AND ENABLING -- BARRIERS TO IDENTIFICATION

One of the most universally accepted and discussed features of all addictive problems is a tendency to deny that a problem exists. Nearly everyone has heard stories, even if he or she has not personally experienced the alcoholic who says, "I don't have a problem with my drinking, you're just overreacting. It's your problem, not mine."

But when addiction professionals refer to ***denial*** they're talking not only about the addict denying. They are also referring to a larger problem in which co-workers, family members, and a variety of helping professionals have often contributed to the continuance of a problem -- "***enabled***" the addict -- by their reluctance to identify the problem. Not only individuals, on a case-by-case basis, but our entire society can be accused of enabling by denying the extent of its problems with alcohol, just as in the past it denied its problems with other drugs.

A number of possible reasons can be identified. Probably the most

often discussed is the possibility that the enabler may be afraid he or she has a problem with alcohol or other drugs. The logic behind this view of denial is that by saying, "That other person doesn't have a problem," one can define "problems" in a way which leaves his or her behavior within the acceptable range. You might say, for instance, that alcoholics are people who drink before noon. So long as you don't drink before noon, then, you're not an alcoholic.

A second possible motivation, one even harder to face, is ambivalence. The enabler may be gaining something from the addict's behavior and may not want to see that behavior change. For instance, if my co-worker is a handy scapegoat because of frequently missing work, I may feel fortunate that my own failures are thereby overlooked. Family members are frequently accused of this kind of "benefit" from the addiction.

Related to this pattern is an opposite one in which the observer doubts the accuracy of his or her observations because they seem to be a result of anger or jealousy. If I am angry at my co-worker and I think he is an alcoholic, then maybe I'm distorting my impressions. This kind of doubt is likely to be greater if there is reason to worry about the kind and amount of treatment the identified person is likely to get. For example, if I am afraid that by reporting my co-worker I will cause him or her to have a horrible experience I am not so likely to say anything. If I felt, on the other hand, that the outcome would be appropriate and that the process of assessment and possible referral would be sensitively handled, I would feel less doubt about taking action.

# D. IDENTIFYING THE ADDICTED INDIVIDUAL

Accepting that denial is a problem, then, and believing that there is an advantage to identifying problems as soon as possible rather than waiting for them to develop into a stage where identification is easy, how can one go about identifying an addictive problem in the early stages?

## Formal assessment.

Identifying a problem requires using some kind of criteria, and in the case of addictive problems there are several different kinds of criteria to choose from. What will be discussed here are some of the more common approaches to identification.

Earlier we mentioned the Diagnostic and Statistical Manual for Mental Disorders, Third Edition-Revised (DSM IIIR), which is one of the most frequently cited sources for diagnostic criteria. The DSM IIIR provides separate criteria for each substance separately and distinguishes between abuse and dependence (it is worth noting that the label, "alcoholism" does not appear here). The criteria for alcohol abuse and dependence differ in that dependence requires not only ***episodes*** of self-destructive alcohol use but a ***pattern*** including at least three of seven criteria such as frequent use of more than the intended amount, persistent desire or unsuccessful attempts to cut down, large amounts of time spent in drinking-related activities, and frequent intoxication or withdrawal symptoms

Less formal, but still involving a set mechanism for decision-making, is the common clinical use of the Michigan Alcoholism Screening Test (Table 6.1). This 25-item questionnaire has repeatedly demonstrated its ability to identify those individuals who would be likely to receive a diagnosis of alcoholism through more formal approaches. Items combine to provide a score which rates the severity of an alcohol problem.

Assessing problem levels in the case of other drug use and non-chemical addictions is a less well-developed specialization. Developing questionnaires for every possible combination of drugs and behavioral addiction is a seemingly impossible task; individuals and agencies which repeatedly address the special issues of a particular problem often develop their own assessment instruments.

A number of self-assessment questionnaires have been developed in recent years to meet the demand from people who want to assess their own levels of use; one such questionnaire is provided in Table 6.2. While such questionnaires are not proposed as 100% accurate in determining the level of a problem with alcohol or other drugs, they can help a person to evaluate his or her behavior in relationship to community standards.

## Clinical Indicators

The procedures described above are ones through which an interviewer or a family member might attempt to gain a reasonably accurate estimate of the severity of someone's alcohol or other drug problem. This section will look at some more intuitive, less objective kinds of information which can help one to look at another's substance use and draw useful conclusions.

**Table 6.1**
**The Michigan Alcoholism Screening Test (MAST)**

| Question: | Points |
|---|---|
| 1. Do you feel you are a normal drinker? | 2* |
| 2. Have you ever awakened the morning after some drinking the night before and found that you could not remember a part of the evening before? | 3 |
| 3. Does your wife, husband (or parents) every worry or complain about your drinking? | 1 |
| 4. Can you stop drinking without a struggle after one or two drinks? | 2* |
| 5. Do you ever feel bad about your driniking? | 1 |
| 6. Do friends or relatives think you are a normal drinker ? | 2 |
| 7. Do you ever try to limit your drinking to certain times of the day to or to certain places? | 0 |
| 8. Are you always able to stop drinking when you want to? | 2* |
| 9. Have you ever attended a meeting of Alcoholics Anonymous (AA)? | 5 |
| 10. Have you gotten into fights when drinking? | 1 |
| 11. Had drinking ever created problems with you and your wife or husband ? | 2 |
| 12. Has your wife or husband (or other family member) ever gone to anyone for help about your drinking ? | 2 |
| 13. Have you ever lost friends or girlfriends or boyfriends because of drinking ? | 2 |
| 14. Have you ever gotten into trouble at work because of drinking ? | 2 |
| 15. Have you every lost a job because of drinking? | 2 |
| 16. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking? | 2<br>1 |
| 17. Do you ever drink before noon? | |
| 18. Have you ever been told you have liver trouble? Cirrhosis? | 2 |
| 19. Have you ever had delirium tremens (DTs), severe shaking, heard voices or seen things that weren't there after heavy drinking? | 5 |
| 20. Have you ever gone to anyone for help about drinking? | 5 |
| 21. Have you ever been in a hospital because of drinking? | 5 |
| 22. Have you ever been a patient in a psychiatric hospital or on a psychiatric ward of a general hospital where drinking was part of the problem? | 2 |
| 23. Have you ever been seen at a psychiatric or mental health clinic, or gone to a doctor, social worker or clergyman for help with an emotional problem in which drinking played a part? | 5 |
| 24. Have you ever been arrested for drunk driving even for a few hours because of drunk behavior? | 2 |
| 25. Have you ever been arrested for drunk driving? | 2 |

Scoring: For each "yes" for all questions except 1,4, and 8, give yourself the points indicated. For questions 1,4, and 8, (marked with an asterisk) give yourself the points indicated for a "no" answer. For question 24, count 2 points for each arrest.

How do you compare? In a study by Selzer (1971), 95% of the control group, 45% of those arrested for drunk driving, and only 2% of those hospitalized for alcoholism scored betwen 0-4 points. Based on this and other findings, a score of "5" or better is generally considered to indicate a person with a drinking problem . Source: Selzer, 1971

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Table 6.2
TWENTY QUESTIONS TO ASK YOURSELF
ABOUT A FRIEND'S OR RELATIVE'S DRINKING*

1. Do you worry about this person's drinking?
2. Have you ever been embarrassed by it?
3. Are holidays more of a nightmare than a celebration because of this person's behavior due to alcohol?
4. Are most of this person's friends heavy drinkers?
5. Does this person often promise to quit drinking, without success?
6. Does this person's drinking make the atmosphere tense and anxious?
7. Does this person deny a drinking problem because he drinks only beer?
8. Do you find it necessary to lie to employer, relatives, or friends in order to hide this person's drinking?
9. Has this person ever failed to remember what occurred during a drinking period?
10. Does this person avoid conversation pertaining to alcohol or problem drinking?
11. Does this person justify his or her drinking?
12. Does this person avoid social situations where alcoholic beverages will not be served?
13. Do you ever feel guilty about his person's drinking?
14. Has this person driven a vehicle while under the influence of alcohol?
15. Are children afraid of this person while he or she is drinking?
16. Are you afraid of physical or verbal attack when this person is drinking?
17. Do others comment on this person's unusual drinking behavior?
18. Do others fear riding with this person when he or she is drinking and driving?
19. Does this person have periods of remorse after a drinking occasion and apologize for unacceptable behavior?
20. Does drinking less alcohol now bring about the same effects in this person that in the past required more?

If you've answered yes to five or more of these questions, your friend or relative definitely has a serious problem.

*Source: George E. Vaillant, M.D., The Natural History of Alcoholism (Harvard University Press, 1983). Reprinted with permission.

Some experts in the field continue to rely on the simple initials C.A.G.E. to remind them of four important indicators of a severe alcohol problem. Different terms have been attached to these initials; one version is:

Cutting down

Annoyance by others (an excuse)

Guilty feelings

Eyeopeners (morning drinking)

Other clinicians depend to a great extent on assessing the individual's family history. It has been statistically demonstrated that children of alcoholics are more likely than others to develop alcoholism themselves. Even when a parent is not alcoholic, a family history with several alcoholics on one side or the other seems to be a strong risk factor, particularly if one believes in a genetic process of transmission.

Another approach is to draw inferences, based on limited information, about what additional information would be if it were available. For instance, some clinicians suggest that one drunk driving ticket is fairly reliable proof of alcoholism; they reason that most people are careful enough when they've been drinking that it's only the habitually drunk person who would be careless enough to get caught even once. Likewise, one arrest for possession of an illegal substance could be seen as the kind of mistake only someone constantly carrying drugs might make. It is not uncommon for interviewers to ask how much of a substance a person is using and to then mentally convert that answer to a larger amount. Once a week, then, becomes at least once a week and more likely daily. "A couple of beers" becomes two 40-ouncers. Of course, these "extensions" of the individual's answers may be wrong; it could be that someone was drunk once and was caught driving that one time.

Finally, a skilled interviewer in the substance abuse field learns to listen for indicators which the client wouldn't have thought to monitor. Sleeping problems, for instance, are often a clue to heavy intake of one or more substances. Loss of appetite, while generally thought of as only related to amphetamine use, may also point to cocaine or to alcohol. And the ability to consume a great amount of alcohol without becoming drunk is a sign that the body has made great progress in adapting to frequent alcohol intake.

It is impossible to perfectly document the existence of an addictive disorder, especially without medical testing and without extensive interviewing by a trained specialist. But whenever signs of a possible problem become strong enough it is

time to take a look at getting the individual into contact with some kind of treatment program.

# E. INTERVENTION

If professional help or involvement in a self-help program seems to be indicated, family, friends, supervisors, teachers, and co-workers must develop a strategy which is likely to get the abuser connected with that help. Many times the subject of getting treatment has been brought up time and time again and the person who's the object of concern has made it clear that he or she doesn't have a problem. If the friend or loved one does agree to seek help, everyone wants it to be the best and the most appropriate. What's to be done?

## Linking people with resources.

It is obvious from our earlier discussions that an abuser (or addict) should get help to avoid further negative consequences as well as to protect loved ones and associates from harm. In the "old days" an alcoholic would have been forced into treatment without much concern about how he or she would handle the experience once there (this still happens to some extent). As a result, treatment programs have often dealt with individuals who did not accept the need for treatment and who, even after two weeks to one month in a hospital setting, would insist that they didn't have a substance problem. Some programs became specialists in handling this situation with a hard, confrontive style which attacked the individual's defenses. Of course, nearly everyone agreed that the more desirable scenario involved a client who felt a need for help and who took some personal responsibility for change.

Some years ago a new approach to getting people into treatment began to develop. This new approach, known as an "***intervention***," is special because of its focus on gaining the individual's cooperation. Rather than forcing the individual to enter treatment, the intervention seeks a voluntary request for help. At the same time, it calls on various sources of leverage to help her get to that point. Using a case study for an example, we will briefly describe one version of the process. Readers interested in exploring this idea further are encouraged to read David Treadway's (1989) Before it's too late and Vernon Johnson's (1980) I'll quit tomorrow. Many other helpful materials are available through city and county health departments, in libraries, and in bookstores.

*Doris had been coming home very late from work recently, generally smelling of alcohol. She used to deny it, saying that the smell came from someone she sat beside on the bus; now she began admitting stopping in a neighborhood bar to "unwind" before she came home to "face the mess." Her mother and her children complained, and she ridiculed them for trying to spoil her one source of enjoyment. One night she didn't come home at all, and in the middle of the next morning she showed up at home; she had been asked to take the rest of the day off and get herself together.*

*Her oldest daughter, whose high school health class had just seen a film portraying an intervention, led the effort to get an intervention organized for her Mom. It took a few weeks, and during that time everyone who was to become involved had to attend meetings to plan together with a therapist. Finally they were ready to confront her.*

*On the evening they had agreed on, Doris came home late as usual and under the influence of a few drinks to find her living room full. Not only her mother and her children were there, she also faced her next door neighbor; her two sisters; her supervisor from work; and the therapist who has helped them plan this intervention. One by one, these people who knew her so well began to clearly describe what they had been seeing; they had practiced putting these things simply and avoiding name-calling. As their stories fit together it became harder and harder for Doris to claim she had no problem. Once those closer to her had spoken, the therapist stepped in to offer help in finding treatment or other assistance. When Doris felt reluctant to take that step, the group discussed what they could do if she chose to continue the path she was on; they talked of her possibly losing her job, seeing her children go with her mother to live elsewhere, finding herself avoided by those she had loved. Doris ended by asking for everyone's help and packed her suitcase.*

This is only one version of the intervention, and it's oversimplified, but it does illustrate the goals and the techniques which became famous through their success in getting former First Lady Betty Ford to seek treatment for her addiction. Versions of this approach can be used in the workplace or school as well as at home, and some experts such as Treadway encourage repeating the process if it doesn't lead to success the first time.

Getting a person such as Doris into treatment can still be difficult even when she is motivated, however. Depending on her access to public or

insurance company funding, she will have a limited selection of places where she may be admitted, and increasingly both public and private facilities require an initial screening before making a decision about admission. In many places the screening is handled by a separate ***central diagnostic and referral*** facility, which may have limited hours of operation. These procedures, while they seem to restrict access to treatment, have been developed to improve the matching of client to resource. We will next discuss resources.

## Resources.

All people's treatment needs are not the same. For example, professionals in the treatment field have begun to realize that women have special concerns which are not shared with men. Treatment programs specializing in women have developed and some existing programs have been modified to include special women's groups. Women with children have come to be recognized as a further special group, one not only having special treatment issues but also having special needs for supporting resources. Members of many professions have also come to be seen as having special needs and concerns: doctors, for instance, find it hard to accept someone else's authority and tend to attack therapists with "lesser" credentials.

In a similar vein, it has been suggested that the treatment which worked for primary users of one drug (the most common has been alcohol) may not be the best thing for primary users of another. Cocaine users, for example, typically seem to be prone to depression; they may respond badly to some approaches which alcoholics, being more prone to anxiety, apparently need to help them relax and relieve tension.

Of course it may be difficult for friends, co-workers, and relatives to know the exact nature of the problem, just as they are not likely to know all the resources which may be available. This is the reason diagnostic and referral programs have come into existence; they are staffed by trained professionals who have access to extensive community data files and know the admission criteria for each kind of program as well as the specifics of different funding sources.

Based on a careful assessment, the referral specialist (or the intake worker at a treatment facility) can evaluate the appropriateness of programs which vary in their length, intensity, staffing patterns, and treatment approaches. Whereas five years ago the majority of clients might have received inpatient treatment in a 21-day program, now there is a greater diversity of programs

**DISCUSSION TOPIC:**
**THE SOBELL AND SOBELL EXPERIMENT**

Perhaps the most famous experiment (or infamous, depending on your point of view), dealing with the behavioral method of treatment for alcohol abusers, was reported by Sobell and Sobell (1973). It was based on a behavioral model and through instruction and reinforcement, the authors attempted to train a small group of problem drinkers to become controlled, or social, drinkers. This experiment, which involved a very few subjects and which was not intended to be a model for all alcohol treatment, generated an enormous amount of controversy.

The authors' report of successful return to controlled drinking was questioned by others who criticized the research and accused the two researchers of professional misconduct at the least, and at the worst, outright fraud (Pendery, Maltzman, & West, 1982). They were cleared of any wrongdoing by a panel of eminent researchers (Marlatt, 1983) although, as is often the case, their exoneration did not gain the headlines that their accusation did.

Debate still rages about the validity and even morality of this experiment. Exploratory though it was, it challenged a basic tenet of faith of some important professionals in the field that total abstinence is the only appropriate goal for alcohol abusers. More importantly, the furor over the research obscured the fact that the Sobells' findings were not new. A number of studies have reported, both before and after their research was published, that at least some problem drinkers do return to social drinking patterns. The real question is not if problem drinkers can moderate their drinking but whether such drinking should be considered a goal.

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including shorter inpatient alternatives, intensive outpatient programs demanding 6 hours per day for 3 weeks, less intensive evening or weekend programs, and traditional once-per-week outpatient group therapy. The decision is based on information about prior treatment attempts as well as indications that the substance abuse problem might co-exist with another mental disorder which was escaping detection.

The nature of treatment itself, not just its structure, is also becoming more varied. Some experts have presented studies which suggest that there are alcoholics who can be taught, through behavioral procedures, to drink responsibly; a few facilities apply this kind of approach when they feel it is appropriate. Drugs are used in some facilities to help relieve the expected distress of individuals undergoing withdrawal, while others use nutritional supplements to hasten the nervous system's healing process. Work with the client's family varies widely; some facilities provide only an orientation lecture or film, while others provide an intense short-term family program and others focus sustained attention on the family throughout its adaptation to the first year or two of abstinence.

Meanwhile, the self-help groups which first changed society's beliefs about addiction continue to bring many people into abstinence and to help them move along the road to a stable, chemical-free, emotionally fulfilling lifestyle. The majority of formal treatment programs, regardless of their structure, either incorporate 12-step groups into the treatment or refer people to go find them on their own. From the Alcoholics Anonymous group as a beginning, the structure and the spiritual/behavioral focus of the 12-Step programs have been extended into many specialized areas. The programs require voluntary participation and therefore they do not meet every need; but for those who come back and use the 12 steps, a quality life beyond mere abstinence is an achievable reality.

# EXERCISES FOR FURTHER STUDY

1. There probably have been times in your life when you have identified acquaintances who seemed to have alcohol and/or other drug abuse problems. Try to remember at least one such occasion, then answer the following questions:

   a. What was your basis for making the determination?

   b. Could you teach others to use the same judgment process?

   c. Do you have any basis for concluding how accurate you were?

   d. Would you handle the same situauion differently, knowing things which you didn't know then?

2. Locate a copy of the film, "The Intervention". This classic film, though not in general distribution, is owned by many treatment centers and local health agencies. It demonstrates a family's preparation for an intervention and shows the alcoholic's response to a careful, loving confrontation.

# RECOMMENDED FILMS

Some of the issues raised in this chapter are illustrated in popular films. The following are among those which are available on videotape and which may be rented for viewing at home or as a class.

When using a film for this purpose, it may be helpful to ask yourself, "What am I looking for?" Some people find a list helps them to keep their attention focused on concepts, images, and issues which are most important to them.

**Barfly**. This is not a film for the faint-hearted. It's hard to know who is more painfully self-destructive in this film, the brilliant, talented alcoholic writer or his alcoholic lover.

**Bright Lights, Big City**. This portrayal of the successful, overachieving cocaine user who can't get off the carousel illustrates the difficulty in identifying cocaine addiction.

**Days of Wine and Roses**. A classic from the early 1960s. Jack Lemmon and Lee Remick create a realistic portrayal of developing alcoholism.

# SUGGESTED READINGS

You are encouraged to do further reading on some of the issues which were the focus of this chapter. The following suggestions are only a small sample of the books you might find interesting and useful. Full references appear at the end of this book.

Assessment of Addictive Behavior, Edited by Dennis M. Donovan and G. Alan Marlatt. This professional volume provides a good review of the current options for screening and diagnosis.

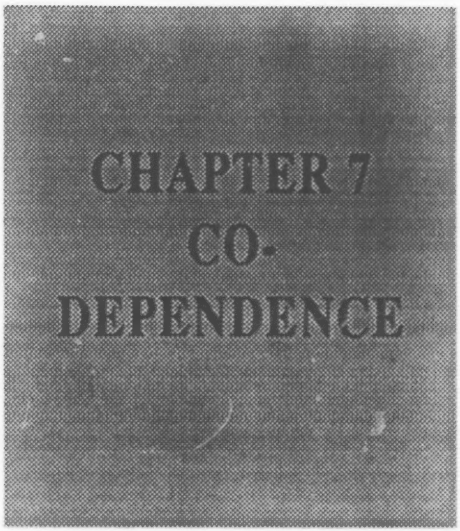
Before it's Too Late: Working with Substance Abuse in the Family, by David C. Treadway. The author skillfully blends current thinking in the often-separate fields of family therapy and substance abuse.

Healing the Shame that Binds Us, by John Bradshaw. This popular book details the powerful impact of shame in the development of chemical dependence.

I'll Quit Tomorrow, by Vernon E. Johnson. A personal story of self-confrontation and change, this book will be especially helpful to those who have not personally experienced an addict's denial.

The Diseasing of America, by Stanton Peele. In this controversial book, Peele has gathered extensive evidence which raises doubts about "the disease concept."

Thirst for Freedom, by David Stewart. Although it was written in the 1960s, this book still holds relevance for the addict's search for the true self, the need to accept the self, and the freedom to experience wholeness in life.




Codependence is a fairly new concept in the chemical dependence field. Ten years ago the word was spoken by only the most knowledgeable, but now many bookstores have entire shelves devoted to codependence titles. This chapter will examine the idea of codependence -- its history, its theoretical underpinnings -- and will suggest ways in which the concept may have both positive and negative implications.

# A. INTRODUCTION

It's likely that people first became aware of the pattern now called codependence when some alcoholics blamed their drinking on their families. Although therapists generally dismissed such blaming on the grounds that "No one can actually make someone else turn into an alcoholic," some researchers began asking questions about the spouse of the alcoholic. Early researchers expected that one of two patterns would be discovered: either emotionally disturbed people would have been attracted to alcoholic partners, or living with an alcoholic would have produced mental illness. But even when samples of these spouses were given a wide range of psychological tests to identify special characteristics, few significant results were found; on conventional measures of mental health, the spouses looked fine.

In a second step in this work, therapists called attention to the fact that not all of the wives seemed to make an effort to change their husbands' alcoholism. Following up on this observation, researchers assigned wives for research purposes

into two groups, one group who clearly sought help for the alcoholic and another group who apparently did not. On measures of mental health there were again no significant findings; this line of inquiry was therefore dropped. At about this same time husbands of alcoholic wives began to be studied as well, and the husbands, too, displayed only normal levels of psychological disturbance.

A breakthrough came after family theories and family therapy began to gain acceptance in the larger arena of mental health. Alcoholism scholars now proposed that the disease of chemical dependence might be a family problem rather than an individual one. Seen that way, all family members would be part of the alcoholic family system and their ***interactions with each*** other would be expected to be distorted by the family disease. Researchers following this trail had more success than their predecessors. When studied in interaction with the alcoholic, spouses did display some unusual and maladaptive behavior (see Steinglass, 1979, for examples). The most dramatic finding of this research was that spouses not only acted differently when together with the alcoholic, they changed their behavior even more when the alcoholic was drinking.

Beginning in the 1970s, a few pioneers such as Charles Whitfield with his concept of the "co-alcoholic" began to define codependence, and gradually the concept broadened. In the beginning, spurred by concerns of the alcohol treatment community, experts were concerned with the way the family members of the alcoholic might be contributing to the alcoholism. In recent years, however, the focus has broadened to include questions about the emotional well-being of the family members themselves.

## The popular movement

Popularizers of the codependence concept, including Wegscheider-Cruse (1981), Schaef (1986), and Beattie (1987), have found a wide audience receptive to their writings & lectures. Many people have identified personally with descriptions of codependence and have found the concept to be helpful in their attempts to address painful, maladaptive patterns in their lives.

A particularly receptive group has been the community of professional helpers -- in medicine, nursing, social work, and many other professions -- and managers whose daily lives

## WHEN HELPING CAN BE HARMFUL*

It is a natural reaction when a friend wants to rescue the problem user from painful consequences resulting from his or her drinking or drug use. This rescue is characterized by denying, covering up for or saving the person from the negative results of their drug/alcohol use, and is called enabling. Enabling only contributes to the user's failure to accept responsibility for his or her actions, so the drug/alcohol use is the most effective means of getting them to consider help. Listed below are some suggestions on ways to prevent enabling.

- **Covering up or making excuses for the person only shields him/her from realistic consequences of his/her behavior** (i.e.: calling in sick for him/her, minimizing the behavior when others recognize the problem). Allow the person to accept the responsibility for his/her behavior.

- **Assuming the person's responsibilities**, such as taking notes in class, paying bills, or taking over household chores only blinds the person to the impact that drugs/alcohol is having on his/her life and makes it easier for the person to continue using. Take a step back and allow the person to struggle with fulfilling his/her own responsibilities.

- **Hiding, dumping alcohol/drugs**, or sheltering the problem user from situations where alcohol or drugs are present is not an effective means of curbing person's use. If the person is determined to use he/she will find alcohol or drugs elsewhere.

- **Don't drink or use drugs along with the person or encourage him/her to.**

- **Do not accept guilt for another's behavior** and do not accept the responsibility for changing another's behavior. The responsibility is ultimately that person's.

- **Be patient**. Getting a person to examine his/her drinking or drugs use can be a slow process. Breaking through the denial is a difficult first step.

- **Let the person know that you still love and respect him/her** as a person but disapprove of and are concerned about the drinking or drug use.

- **Encourage the person to participate in leisure time activities which don't include drinking/drugs.**

- **Understand your own feelings of anger, depression and frustration** which often accompany being closely involved with a problem user. Speak to a counselor or join a group such as Alanon, Alateen, or Nar-Anon, which offer support and suggestions on how to deal with the person who is abusing alcohol or other drugs.

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involve struggling with chemically dependent people. Some experts consider the majority of helping professionals to be codependent. If codependent patterns do exist among such professionals, their effectiveness would be seriously reduced in ways which should become clear in this chapter. At the same time, because of short-term advantages to a treatment organization or other employer, codependent behavior is rarely challenged or referred for treatment.

### Challenges

A number of prominent thinkers (for example, Gomberg, 1989 and Treadway, 1990) have raised questions about possible overuse of the codependence concept. The critics are concerned that people with problems, now labeled as codependent, will feel discouraged and will assume they now have an excuse for failure. Critics note that most buyers of codependence books and most attendees at codependence workshops are women.

Critics also are concerned that the message in some codependence literature seems to encourage selfishness and to discourage caring--therefore possibly contributing to a breakdown of already-weakened family & societal relations. The reader will have to decide for himself or herself whether or not these concerns limit the usefulness of the concept.

## B. DESCRIPTIONS OF CODEPENDENCE

Even though the concept of codependence is being challenged, most observers agree on kinds of behavior which frequently appear among members of families containing chemically dependent individuals. Although these characteristic behavior patterns are not always severe enough to be considered problems, in some cases they may be disabling in their effects on the codependent and on his or her family, work, and other relationships.

Described below are some of the behavior patterns which have been identified as typical of codependents. Lists of codependent behaviors can get quite long. Beatty (1988), for instance, lists nine pages of

codependent behavior problems. More conservative authors include only those characteristics which best discriminate between codependents and others. The following categories of codependent behavior are ones on which there is general agreement. (These descriptions are not intended to explain why the behavior occurs; that discussion will follow in another section).

## Caretaking

The most prominent feature of the codependent may be the tendency to take an unrealistic amount of responsibility for others' behavior. Given a class project shared with three other students, the codependent will not only gather phone numbers, set up a meeting schedule, assign tasks, and follow up the assignments with phone calls, but will even go to the library for team members' books and clear the teammates' presentations with the professor.

At home this is the family member who remembers everyone's schedules and takes responsibility for making sure that they go to work, attend class, remember dental appointments, and pick up their pay checks. With a codependent around there is no need to pick up wet towels off the floor, set an alarm clock, put gas in the car, or even pick out clothes in the morning; these things just get done automatically.

## Self-denial

The caretaking described above is most obvious when contrasted with the codependent's tendency to overlook his or her own needs while taking care of others. "Don't worry about me" is a favorite saying. In the process of taking care of others the codependent person will risk physical and financial ruin, give up sleeping and eating, go through snowstorms and traffic jams -- to save another person a few minutes' inconvenience. Codependent people cannot (actually, will not ) say "No" to any request, however unreasonable. It sometimes appears to an observer that they are going out of their way to make themselves suffer.

## Control

Those in the codependent's sphere of influence, despite the caretaking, may not feel particularly cared about -- and they are not likely to feel guilty about the self-denial of their caretaker.

When they notice the behavior at all, they are likely to feel controlled by this other person's attempts to do things for them. The codependent is likely to helpfully choose clothes, rearrange furniture, and zip jackets, and may be quite punitive to those who resist the program. The "well-meaning" efforts of the codependent have the overall effect of making sure that things happen his or her way, but only in the immediate present. Over time the controlling person may experience such a backlash that even the most reasonabe goals are frustrated.

## Suspicion

Not surprisingly, codependent people are prone to suspect others of either trying to control things or trying to get away with something they shouldn't. This belief in others' antisocial tendencies generally is not extended to the world at large, but is targeted at particular people who are interfering with the efforts of the codependent who is "only trying to help them." This pattern leads to emotional isolation and constant stress.

## Self-criticism

Even as codependents impose their own way of doing things on others, they may frequently talk about being uneducated, unskilled, and dumb and may call undue attention to others' accomplishments. This goes beyond the normal, polite "You do such a nice job with flowers, I just can't ever make anything grow." The way in which codependents repeatedly focus on their faults and inadequacies is exaggerated, unrealistic, and disabling as they avoid opportunities for advancement and deny themselves honors.

## Reactivity

The codependent is often hooked into other people's feelings to a disturbing extent, responding with anxiety and renewed effort when others seem dissatisfied or angry. At the extreme level, the anxiety about others' reactions can lead to being "frozen" with fear. It can also have the paradoxical effect of encouraging others' out-of-control behavior, as seems to happen with the alcoholic.

## Denial of feelings

Overconcern with others' feelings generally goes along with a lack of self-awareness. Codependents are likely to deny that they ever experience anger, depression, or even disappointment. When they come close to talking about their own feelings it often is done through their interpretations of how someone else must feel. A popular joke refers to a dying codependent wife who saw her husband's life flashing before her eyes.

## Inconsistency

For many codependents the self-denial and caretaking wear thin at times and there are times when they feel unappreciated. At such times there may be a drastic mood change or alteration of behavior; the person who was giving and open suddenly becomes resentful, self-protective, and closed.

## Risk of addiction

There are many similarities between the feelings underlying codependence and those underlying addiction. It does appear that large numbers of people handle codependent tendencies by using alcohol or other drugs or by engaging in other addictive behaviors. This response makes a difference which is not really a difference -- that is, while the nature of the person's self-destructive behavior has changed the new behavior is just as problematic as the old one was.

**DISCUSSION TOPIC:**

**THE CONTACT LENS TEST: A DIAGNOSTIC TOOL**

If one characteristic of the codependent is an uncommon sensitivity to others' distress, then one way of finding a codependent in a crowd may be to announce, "I've dropped a contact lens." The last person to give up the search and leave the room, naturally, would be the most codependent -- the one who can't handle the idea that someone is going to be upset.

# C. WEGSCHEIDER'S FIVE FAMILY ROLES

Sharon Wegscheider, (1981) in a thoughtful discussion of roles in families, identified a cluster of family roles which she frequently observed in chemically dependent families. Each of these roles, or parts in the family drama, has some of the codependent characteristics discussed above. Each also, however, has other characteristics which contribute in positive ways to the family. The roles are not necessarily indicators of family problems; they appear to some extent in all families.

The five roles identified by Wegscheider have become a significant part of the codependence literature. Clinicians and clients alike find the role descriptions to represent some family realities and clients often are encouraged to choose one role with which they most strongly identify.

This use of the role concept , however, may be counterproductive. The original theory of roles in families emphasized that roles are flexible and they are not the same as identities; the fact that someone is taking the role of Hero in the family does not mean that the person must always do the same thing or that someone else cannot also perform that role. With the understanding, then, that these roles are not real, they are not fixed or permanent, and they are not necessarily dysfunctional, the following brief role summaries are presented.

The ***enabler*** protects the chemically dependent individual from the consequences of his or her actions; this includes calling the boss to make apologies and driving home when the drinker is too intoxicated to be on the road. The ***hero*** counteracts the family sense of inadequacy by performing at the highest possible levels in school, the community, and at home; the hero's overachieving is a model for all, who of course are unable to match this performance. The ***scapegoat*** takes the family's anger, hostility, and frustration, and sense of inferiority and displays it for the world to see; this may be done through chemical use, sexual acting out, or criminal behavior. The ***lost_child*** self-sufficient and quiet, gets ignored in the daily uproar; he or she develops a fantasy life or other separate existence to replace family interaction. Finally the ***mascot*** is a clown, the life of the

party; he or she distracts others from their problems and covers up feelings with humor.

# D. PERSPECTIVES ON CODEPENDENCE

The reader going through the preceding discussions of codependent behavior patterns may have found the identified behaviors puzzling or, on the other hand, may have felt that they all made sense and fit into a logical pattern. If they fit, it is probably because the reader already has some kind of a theory which explains codependent patterns, though the theory may not be one that can be stated to others.

In this section some different approaches to the codependence question are presented. These approaches are not offered as necessarily better than others; they should only be adopted if they feel appropriate and they explain this phenomenon better than the theories one already has.

## Shame

According to this perspective, the chemically dependent family is one dominated by a general feeling of shame. This shame, a feeling that the individual is somehow not as good as others, is seen as both a cause of addictive behavior and as a result of the humiliating, painful, and destructive consequences of the behavior. In the case of the codependent the shame may lead to (a) attempts to cover up one's imperfections and the imperfections of others through a rigorous campaign of control; (b) attempts to make up for being so worthless and inadequate; and (c) an attraction to out-of-control situations where one's crisis-management skills will finally be appreciated. These strategies for finally be feeling better are doomed to failure, of course, thereby increasing the sense of shame.

Shaef (1986) proposes that modern society contributes to shame and low self-esteem through the scarcity of personal relationships and the need to constantly prove one's self-worth. She sees codependence not as a disease affecting a few people, but rather as a nearly universal tendency which some people demonstrate more than others. Shaef strongly encourages individuals and society to consider a change in

life-style in which people would incorporate a stronger emphasis on the spiritual side of their lives, thereby counteracting the shame-promoting aspects of society.

## Belief in Control

Bateson (1971) theorized that chemical dependence results from an incorrect belief -- a belief that one should be able to achieve control over one's experience. Pointing to the AA demand that the individual accept a lack of control over alcohol, Bateson suggested that modern Western civilizations in general are handicapped by believing that the individual should be in charge of his or her behavior.

From this perspective codependence is merely an exaggerated version of the societal problem; the chemically dependent sub-population, including codependents, support each other's distorted view of a world in which it seems everyone else is achieving perfection. Bateson proposed that mental health would be achieved through a posture which parallels the serenity prayer of AA: "God, grant me the serenity to accept the things I cannot change, courage to change the things I can, and wisdom to know the difference".

## Family systems

Steinglass and his associates (1987), along with other family scholars, focus on the ways in which other family interactions adapt to fit together with excessive use of alcohol or other drugs. As the family's systemic pattern has developed over time along with the chemical dependency, no one person's behavior can be seen as having "caused" the other. From this perspective the emotionally guarded, overcontrolling codependent's behavior is an essential part of a systemic pattern and therefore is adaptive and functional considering the circumstances. Steinglass and his co-authors assert that without a concerted family effort to end the dependent / codependent pattern, parents will generally transmit the pattern to their children.

## Sex roles

Finally, a large number of authors have pointed to the considerable parallel between codependence, as usually described, and the normal expectations for women in most societies. They suggest that the organi-

zation of society around an assertive, success-oriented male role and a passive, self-effacing female role has benefitted men and has promoted codependent tendencies among women. Many of these authors call for a dramatic reversal of woman's behavior, making a more self-centered lifestyle the norm.

## E. IMPLICATIONS

Shaef (1987) suggests that codependence is widespread among a large group of people who are not very different from others. Beattie (1987), on the other hand, believes that the codependent is a unique person who has special needs and concerns. Regardless of which view one espouses, the discovery of some codependent tendencies in the self should lead to some actions to counteract these tendencies.

First, a person who recognizes codependent characteristics in himself or herself should assess the extent of (both current and potential) impact on family and professional life. In many cases it will be seen that the codependent behavior is quite destructive. This assessment should lead to initiating a program of recovery from the codependence. If the behavior is disrupting work and family life, it may be necessary to arrange so that others can handle responsibilities which cannot be managed in an appropriate way. Awareness of codependent tendencies can allow one to monitor on a daily basis and reduce codependent behavior when it begins to surface.

For many people, a 12-Step program is an excellent way to begin recovery from codependence. The blend of realism and spiritual emphasis in these self-help programs seems to be very helpful in counteracting some codependent feelings and behaviors. The need for a self-help group may be greater when one's current circumstances are ones which reinforce the codependence; if one is married to a chemically dependent person or if one works in constant contact with chemically dependent clients, it is very difficult to establish and maintain a quality recovery without help.

Addionally, other parts of the social environment may be contributing to the codependence. If, for example, a person had a group of friends who all shared a high level of codependence it would be hard to imagine making major changes

without disturbing the friendship. It is a frequently stated opinion that alcoholics and other drug addicts must establish new social support systems in order to successfully adopt a sober lifestyle. The same may be true of the codependent.

However, granted that the person experiencing the most extreme level of this overconcern is not doing much good for him/herself or others... Do we really want a society in which no one will stop and help another? How can people find a balance point between overinvolvement and isolation?

# EXERCISES FOR FURTHER STUDY

Codependent behavior is easily observed in public places. Because of a tendency to sacrifice their own needs for the approval of others, codependent people may offer compulsive apologies, may try to assist others who do not want the help, or may offer a barrage of self-blaming statements.

Nearly any site offers opportunities for some naturalistic research on this behavior pattern. A bench at the mall, a table in a fast-food restaurant, or a seat on a bus is all that is needed. As a naturalistic observer you must be careful to not stare or call attention to yourself. Once your subject becomes aware of being watched, you have lost the opportunity to see his or her normal behavior pattern.

Try a brief session -- 15 minutes, for example -- at first, allowing at least an equal amount of time afterwards to recall what you have observed and take notes.

Some questions:

1. Did your subjects show their codependent behavior more with strangers or with their companions?

2. Did others seem to accept the behavior as normal, or were there complaints and other comments indicating that it was unacceptable?

3. Was the codependent behavior you observed adaptive? That is, did it achieve its goal or some other positive goal?

# RECOMMENDED FILMS

Some of the issues raised in this chapter are illustrated in popular films. The following are among those which are available on videotape and which may be rented for viewing at home or as a class.

When using a film for this purpose, it may be helpful to ask yourself, "What am I looking for?" Some people find a list helps them to keep their attention focused on concepts, images, and issues which are most important to them.

**Cyrano de Bergerac**. The 1990 remake of this classic story eloquently portrays the self-hate and the distorted perception of reality which characterize codependence.

**The Great Santini**. In this film adaptation of Pat Conroy's novel, the mother demonstrates a classic mix of frustration and "enabling" as she deals with her four children and an alcoholic husband.

# SUGGESTED READINGS

You are encouraged to do further reading on some of the issues which were the focus of this chapter. The following suggestions are only a small sample of the books you might find interesting and useful. Full references appear at the end of this book.

Codependence: Misunderstood -- Mistreated, by Anne Wilson Schaef. One of the most authoritative books on this subject, this readily obtained paperback avoids rhetoric and promises no easy solutions.

Healing the Hurt, by Rosalie Cruise Jesse, emphasizes the importance of involving children in their parents' recovery process. She states that the relationship between chemically dependent, or any other dysfunctionally identified, parents and their children, can be mended.

Understanding and Treating Codependence, by James A. Kitchens. This professional therapist's reference work uses case examples to illustrate issues in working with adult children from highly dysfunctional families.

If this book has accomplished its objectives in previous chapters the reader is familiar with a series of themes which, from the authors' perspective, seem to be at the heart of a non-addictive lifestyle. In this chapter these themes will be pulled together and integrated into a "prescription" which is equally applicable to individuals who are (1) attempting to initiate recovery; (2) attempting to maintain the momentum of recovery; or (3) concerned that their lifestyles are leading in directions which could make addictive problems likely.

This chapter is an attempt to bring together science, folk wisdom, and the spiritual tradition which lies at the heart of AA and the other 12-Step groups. While a life lived according to the principles described in this chapter is not guaranteed to be problem-free, the experience of thousands of individuals indicates that addictive problems are more likely when these principles are ignored.

## A. CHOICE

The first theme has to do with the essential freedom which life offers and with the need, on a minute-to-minute basis, to exercise choices. Problems with this aspect of reality typically take several forms. Some people deny the power of choice by believing that their actions are not their own. They blame every occurrence on circumstances, often becoming angry at the unfairness of life. Others conclude that there is no basis for making choices and that life is absurd; they aren't angry, they welcome the failures which prove that any attempt at control is futile. And finally, some people see making choices as a test of their self-worth. They often become overwhelmed by the stress of attempting to be perfect at choice-making.

Possibly the central choice, then, is a choice of realities. This choice is never totally made in a final,

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irreversible way; rather, it is continually being reviewed in daily life and can be modified. But people tend to adopt, at least as early as the preschool years, a rather obvious posture in relationship to the world. Developmental psychologists have described how these styles of interaction develop through interactions with caregivers and others. People who are dissatisfied with their ways of living have avenues available for making drâmatic change, however. Psychotherapy, self-help groups, organized religion, and individual spiritual quests offer contexts for examining one's basic life choice.

One way of looking at this choice is to see it as a choice between one's real self and illusions about one's self. The person who chooses reality must come to grips with the fact that he or she is not all-wise or perfect, and must learn to live with some limitations. By the time of entry into adolescence the average person is in a position to make this choice, having developed some powers of logic. There is usually enough evidence of imperfection, based on experiences with family, friends, school, and the community. The choice of reality is frightening, though; being less than perfect means that one will sometimes fail and that some goals will not be met. Fear can lead to the choice of an illusion, one in which every day is beautiful and every contest is won.

This illusion is something most people hang on to to some extent, especially through childhood and adolescence. Many traditional fairy tales such as Cinderella portray this kind of belief: "I will be discovered some day and then I will given the power and glory I deserve." The more difficult one's real life, the more tempting it may be to believe that it will some day change all by itself.

Illusions about the self can lead to painful experiences which make problems worse. Many people, for instance, have experienced the disappointment of finding out that they misjudged their attractiveness and charm when they wanted to start dating. They found out that the potential partners they chose were not interested in them, and that the ones who were interested were not always good-looking or nice to be with. Similarly, entering the job market people sometimes misjudge their marketability. Everyone has known a few people who, in their personal and their student or professional lives, seem to consistently ignore all the negative feedback they receive from others. They go from disappointment to disappointment, refusing to learn how they might be more successful.

Another way of looking at this choice, then, is to see it as choice between accepting and not accepting

reality. Some realities can be pretty hard to choose. For Cinderella it would be painful to look at the possibility of years and years of sweeping up ashes, wearing ugly clothes, and doing her sisters' hair. But the refusal to accept reality can keep people from taking effective action on their own behalf. Cinderella, for instance, in modern times might have the option of taking an occasional class at the community college and being discovered not for her beauty but for her intelligence. Waiting for Prince Charming, she would consider the community college an unlikely place to meet him and she would stay by the fireside waiting for the mice to turn into footmen.

## B. POWER, CONTROL, AND POWERLESS-NESS

The second theme, closely related to the first, has to do with the vulnerability and powerlessness which is central to human existence.

Developmental psychologists believe that the well-cared-for infant begins life with an impression of being all-powerful, and only gradually learns that others are separate beings with the ability to disagree. This ideal early experience is only achievable when one's needs are met automatically; when the environment seems to be in synchrony with one's desires.

Erik Erikson (1963) suggested that the infant gains from such an early experience a sense of trust. Because of this trust, the young child can comfortably learn about and accept his or limited degree of control. If we contrast this picture with one of a child growing up in an environment which does not respond to his or her needs, in which it takes a massive investment of crying and fussing to get fed, for instance, we can see that the second child would have a much harder time trusting the world to do the right thing. We might expect of this child, then, a greater desire for power and control.

While some of the impetus toward control may result from such early experience, it is also possible to identify other factors which also support a control orientation. One is the achievement focus of our society; when one's worth is measured by what one achieves, it is hard to trust the environment to provide enough rewards. In fact, people who accept what is given to them may be ridiculed as weak and lacking courage.

Additionally, as mentioned above, Bateson (1972) identified an

unrealistic belief in the possibility of control which, he said, characterized modern society. He identified this belief in control as the essential problem in the addiction to alcohol (he did not examine other addictions). Alcohol, as he viewed it, enabled people to come close to living up to their expectations about controlling their feelings and their behavior; these were unrealistic expectations, which they otherwise could not possibly meet.

This failure to live up to one's expectations is closely related to another issue, which Erikson saw as the next one following trust. He believed that children low on trust would fail to develop a positive sense of their differences from others (autonomy, in his terms) and would instead develop a sense of shame. In recent years this concept of shame, as described in the previous chapter, has been proposed as a major factor in people's tendencies toward addictive behavior patterns. If one believes that others must be kept from knowing about one's terrible secrets, then a desire for power and control is natural.

## C. SELF, OTHERS, AND LOSS OF SELF

The final theme concerns the isolation people can feel even when surrounded by caring others. This isolation, voluntary though it may appear, seems to be a result of a difficulty in making real contact with others. We believe that this pattern results from a deeper problem with oneself.

Contemporary society leads naturally to lifestyles in which people are isolated. Even in the small town people may, in contrast with earlier generations, avoid social contacts by staying inside their homes with their television, videotape, and other electronic toys. Furthermore, these electronic devices can create distance even for residents of a household; for instance, people may all watch different television programs in different rooms.

In cities the isolation of modern life is magnified; even though people are surrounded by others, their lives are fragmented as they spend small parts of their lives in contact with a constantly changing groups of others. The nature of the contemporary job market seems to make it hard for

people to stay in one workplace for very long, and many families move almost constantly as they follow the available jobs.

But this discussion of difficulties with closeness should not be interpreted to refer only to those who remain physically isolated. Many people who are exceptionally involved in interactions with others can be seen, on closer examination, to handle these interactions in ways which prevent real intimacy and which leave them in reality quite isolated. It is paradoxical that some of the safest ways of keeping others at a distance include professional or personal helping roles as caretaker, helper, and teacher.

Sociologists say that people only learn who they are through other people's responses to them: this phenomenon was identified by Cooley (1922) as the "looking-glass self." In a social setting which involves consistent, intimate contacts with others this kind of feedback comes naturally with comments such as, "That's just like you, always worrying about someone else" or "That's what I thought you'd do, grab the biggest piece." When people lack the constancy (or intimacy) of interaction with others they are faced either with a poverty of responses -- no one will say anything meaningful -- or with comments from others whose opinions cannot be evaluated.

It seems that there have always been some people who had problems with themselves and others. Returning to the personality theory of Erikson, he said that at some point -- generally in adolescence-- one should develop a strong sense of identity. He believed that it was only with a confidence in one's sense of self that a person could take the risk of getting close to others.

Many people continue to believe that Erikson's description of this process is correct, and they see the shy or avoidant person as fearful. The fear, according to this perspective, is that the other person will overcome the weak self and -- remember Cooley -- make the self into someone else. This theme, with the dominant person overwhelming the weaker one and changing his or her personality, is one which has a long tradition in literature, films, and folk stories.

With the rise of feminist scholarship another perspective is beginning to emerge. Some see it a a new perspective, while others (for instance, Eisler in her book The Chalice and the Blade, 1987) suggest that it is a return to traditions long buried by a male-dominated society which emphasized power and control . This perspective, reflected in the work of authors such as Carol Gilligan (1982), sees identity as possible (for some people) only if intimacy has

been achieved. Rather than assertively establishing their identities, then, these people (more often women than men, apparently) prefer to negotiate their identities with those who are 'meaningful to them. Problems of closeness, then, may indicate that one partner doesn't trust the relationship enough to let it become the basis for his or her personhood.

Depending on the viewpoint one adopts, then there are two possible avenues to overcoming a difficulty in getting close to others. One avenue, popularized during the 60s and 70s with the slogan "I'll do my thing and you do your thing, and if we happen to meet it's groovy," is to pursue individuation. Some experts advise married couples, for instance, to make sure that they each have separate interests so they can "own" a piece of themselves which is unique. This approach seems to work for some people. It also, however, seems to lead others towards an increasing sense of isolation and fearfulness.

The other avenue is the total opposite. It involves taking more risks, adapting more to others, and when it's hard to trust, adopting the "act as if" principle. That is, by acting as if one is trusting, one becomes more trusting. This approach is consistent with a teaching within some spiritual traditions, that "to find oneself requires losing oneself." And herein lies one of the most difficult challenges confronting those who attempt to live by these principles: How does this selflessness, this openness to others' ways of seeing the world, differ from codependence? Isn't this the same "devote yourself to pleasing others" which the codependence authors are fighting?

## D. BALANCE: PRAYER, MEDITATION, AND SELF-REFLECTION

Here we are getting into some rather tricky waters, because the bulk of the writing and teaching about this aspect of life has been done within one or another spiritual tradition. While many people have found such writings and teachings useful, it appears that a large number of others have great difficulty with any spiritual tradition. We will attempt here, then, to avoid the jargon of any particular tradition.

Going back to the basic premise that addictive problems are the result of a distortion in people's handling of power and control, it is possible to see giving up too much power as a distortion just as trying too hard to achieve power is a distortion. A balanced society requires that people each take a fair share of the responsibility for decision-making. After all, if everyone waits to see what others are going to do, no one will act. Similarly, in achieving intimacy in relationships it is not enough to seek a better understanding of the other and his or her feelings; one must also be willing to express some feelings as well.

Abandoning the attempt to organize the world through the force of one's will does not equal accepting anything the world offers. There is a difference between saying, "I insist on pure silk sheets, and I won't sleep here until you get them" and saying, "It appears that this bed has been used since it was last changed. I believe that sleeping on someone else's sheets will needlessly expose me to disease." The hard part is being able to see which one is doing. The codependent person consistently errs on the side of assuming that he or she is being too demanding. The addict, it seems, typically errs on the side of assuming that others are being too demanding.

The different traditions of prayer, meditation, and self-reflection are all ways of trying to get outside one's own immediate perceptions so as to act in a way which is genuine and appropriate. Whether the decision is based on insights or inspirations, the person who has a way to step out of the flow and process what is going on seems to be able to live in a more balanced way -- neither power-hungry nor powerless.

Possibly the most challenging aspect of living in balance with the world is the fact that there are others -- sometimes our own family members and other intimates - who are not themselves in balance. Maintaining family relationships and work relationships under these circumstances is among life's greatest challenges. Many people who are living with daily challenges of this type find it helpful to have a place -- a support group, prayer group, or therapy group -- where they can enlist the help of others in stepping outside their own subjective experience to gain greater clarity when things are most confusing.

But there are many routes to achieving a balanced state with the world. For some people a personal journal is the most useful tool, whereas others find as did Thoreau that time alone in the out-of-doors helps them to achieve clarity and ac-

ceptance. And others find meditation possible even in a crowded subway car. For many people, particularly those who grew up in a strong religious tradition, the shrine or place of worship has a special role. What is important is that each person find a source of balance which works for him or her.

# EXERCISES FOR FURTHER STUDY

1. Most of the 12-Step recovery groups have special meetings designated as "open meetings" at which non-members are welcome. Call the local information number for a group, or ask around to find out how to locate a group, and attend an open meeting OR locate a meeting of Al-Anon, which is open to participation by anyone who feels his or her life is affected by others' substance use.

Afterwards, write out (or discuss with friends and family) your answers to these questions:

a. How does the group compare with what you expected?

b. Did you develop a different perspective on the life of the addicted individual?

c. Would you have a hard time coming to a meeting of this group and ac knowledging your need for help?

2. Go to a bookstore and count the number of different titles available in the section (s) devoted to addictions, recovery, etc. How many titles make some reference to spirituality, 12 steps, or acceptance?

3. Interview a recovering addict/alcoholic. You should pay special attention to his or her ways of handling life stresses which, in the past could have triggered a relapse.

# RECOMMENDED FILMS

Some of the issues raised in this chapter are illustrated in popular films. The following are among those which are available on videotape and which may be rented for viewing at home or as a class.

When using a film for this purpose, it may be helpful to ask yourself, "What am I looking for?" Some people find a list helps them to keep their attention focused on concepts, images, and issues which are most important to them.

**Brian's Song**. This is a film about two professional football players, one of which contracts a fatal disease, and how the love and support of the other allows both to experience acceptance and peace.

**Chariots of Fire**. Set in the 1924 Olympic games, this story follows a runner whose spiritual life is an essential part of his athletic prowess.

# SUGGESTED READINGS

You are encouraged to do further reading on some of the issues which were the focus of this chapter. The following suggestions are only a small sample of the books you might find interesting and useful. Full references appear at the end of this book.

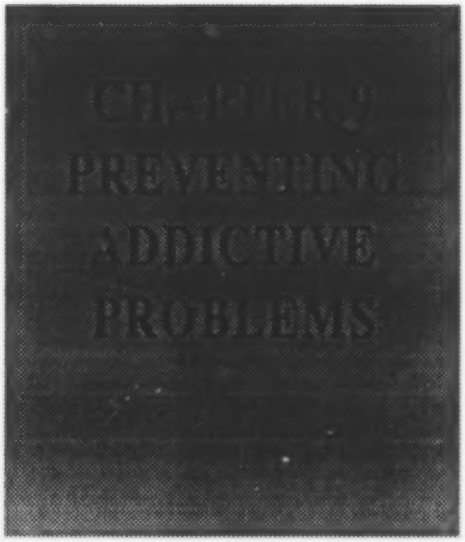
Addiction and Grace, by Gerald G. May, takes the position that all human beings experience a form of addiction and that this represents an attempt at complete control over our lives. He states that it is only through grace that peace can be attained.

Alcoholics Anonymous: The Story of How Many Thousands of Men and Women have Recovered from Alcoholism, by AA World Service, Inc. This "Big Book" of AA has provided inspiration and guidance for individuals and developing chapters all over the world. Many other 12-Step organizations which have modeled themselves on AA have all published their own "Big Books" which generally include the same mix of personal stories and guidelines for recovery.

Perfectionism: What's Bad about being too good? Author Adderholt-Elliott outlines the impossibility of achieving such a state, but also speaks to the anxiety and stress that accompany such striving as well as the high expectations and critical assessments of others leads to the loss of significant relationships and goals.

Spirituality and Recovery, by Father Leo Booth, encourages the reader to live life to the fullest, and presents many successful examples.

The Road Less Travelled: A New Psychology of Love, Traditional Values and Spiritual Growth, by M. Scott Peck. Dr. Peck is a popular workshop leader and his book, a self-proclaimed integration of psychiatry and spirituality, has been on the best-seller lists for years.




At this point in this book it seems as if it shouldn't be necessary to discuss what prevention is all about. After all, didn't we start off with a discussion of what substance-related and other addictive "problems" are, and then go on to identify reasons these problems may come into existence? Obviously, the goal of prevention must be to make sure these problems never come into anyone's life, right?

While this single broad goal may accurately represent the hope of most prevention professionals, it seems to be pretty far off in the future. As we have shown, addictive problems are complex and they are promoted by many aspects of societies; by the existence of highly rewarding activities; and by personal characteristics of individuals which are, to some extent, the outcome of patterns of childrearing as well as unique experience. When these factors are considered, the prevention worker is likely to start looking for, first, ways of reducing the occurrence of addictive problems, and, second, ways of reducing the impact -- duration, severity, and complications including poor health -- of the addictive problems which occur. These more achievable goals will be examined in this chapter.

## A. CATEGORIES OF PREVENTION

The most visible, and the most well-known, kinds of prevention efforts are the ***supply side*** efforts which restrict access to drugs. In this country there has been a gradual increase over the past 100 years in the number of drugs which have been considered dangerous and which have been brought under some kind of legal restriction. Under current laws drugs are subject to differing levels of control, depending on their perceived potential for becoming societal problems. (See Table 9.1, Michigan Drug Law Summary)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At the highest levels of restriction -- those applied to heroin and several other substances -- no importation or production for any purpose is permitted because the drugs are considered to have no acceptable use. For drugs scheduled lower on the list, some limited use is permitted under strict controls. Not only the amount of control, but also the degree of penalty for illegal use varies with the assigned level of the drug; possession of heroin is a felony punishable by possible incarceration, while illegal possession of alcohol is a civil offense subject to much milder penalties.

The alternative to this supply side approach is a ***demand side*** approach which attempts to forestall problems by addressing the user; from this perspective, prevention consists of preparing people to handle the existence of drugs. The particular goals for special populations may be different, with some seeking strategies for maintaining abstinence and others seeking to learn how to be responsible users of legal substances.

Examples of demand side prevention efforts include school coursework, the Red Ribbon campaign of the Mothers Against Drunk Driving (MADD), and the national campaign to distribute television commercials such as the one comparing a frying egg to the brain "on drugs." Demand side efforts are usually the responsibility of prevention professionals; supply side efforts tend to be the responsibility of law enforcement officials and legislators.

Prevention efforts can also be usefully divided into three levels, depending on the history of the individuals whose needs are being addressed. ***Primary prevention*** is directed at those who have had no previous experience with a particular drug, or with drugs in general. That is, a person who is a user of alcohol could still be the subject of primary prevention efforts concerning marijuana. Secondary prevention addresses individuals who have had some experience with the particular substance but whose use has not reached the problem level. Research indicates, for instance, that on the average college campus discussion of alcohol is primarily a secondary prevention effort because most students have used alcohol and have not developed problems with its use.

Finally, ***tertiary prevention*** focuses on people whose drug use has become problematic, but has been brought under control -- generally by abstaining from all drug use. Recovering alcoholics and drug addicts are a tertiary prevention audience.

Table 9.1

SUMMARY OF MICHIGAN DRUG LAWS
Schedule 1 and 2 Narcotics and Cocaine (any mixture)

| Amounts | Delivery, possession with intent to deliver, and manufacture | Possession (sect. 333.7403) | Use (sect. 333.7404) | Examples of chemical names, brand names, and/or street names |
|---|---|---|---|---|
| 650 grams and over | felony<br>mandatory life[2,3] | felony<br>mandatory life[2,3] | N/A | NARCOTICS:<br>heroin<br>morphine<br>opium<br>codeine<br>oxycodone (Percocet), (Percodan)<br>hydromorphone (Dilaudid)<br>pethidine (Demerol), (Meperidine)<br>methadone (Dolophine) |
| 225 grams and over, less than 650 grams | felony<br>mandatory 10 to 30 years[1,2,3] | felony<br>mandatory 10 to 30 years[1,2,3] | N/A | |
| 50 grams and over, less than 225 grams | felony<br>mandatory 5 to 20 years[1,2,3] | felony<br>mandatory 5 to 20 years[1,2,3] | N/A | |
| 25 grams and over, less than 50 grams | felony<br>mandatory 1 to 20 years, and may be fined up to $25,000 or life probation[1,2,3] | felony<br>mandatory 1 to 4 years, may be fined uo to $25,000 or life probation[1,2,3] | misdemeanor<br>up to 1 year/$2000<br>or both | |
| Less than 25 grams (any amount) | felony<br>mandatory 1to 20 years; up to $25,000 or life probation[1,2,3] | felony<br>up to 4 years, or fined up to $25,000 or both | misdemeanor<br>up to 1 year/$2000<br>or both | |

(1) The court may depart from the minimum term of imprisonment with substantial and compelling reasons.
(2) A term of imprisonment imposed pursuant to these sections shall run consecutively with any term of imprisonment imposed for the commission of another felony.
(3) Not eligible for probation, suspension or sentence, or parole during the mandatory term (except as provided for life probation), and shall not receive a reduction in mandatory term of imprisonment by disciplinary credits or any type of sentence credit reduction.

## Other Schedule 1,2,3 Except Marijuana and unless otherwise prescribed in other sections -- any amounts

| Delivery, possesion with intent to deliver, and manufacture | Possession (sect. 333.7403) | Use (sect. 333.704) | Examples of chemical name brand names and/or street names |
|---|---|---|---|
| felony<br>up to 7 years, or<br>fined up to $5000,<br>or both | felony<br>up to 2 years, or<br>fined up to $2000,<br>or both | misdemeanor<br>up to 1 year/$1000<br>or both | DEPRESSANTS:<br>amobarbital<br>secobarbital<br>pentobarbital (Nembutal),<br>phencyclidine (PCP),<br>pentazocine (Talwin)<br><br>STIMULANTS:<br>amphetamine (Biphetamine,<br>Obetrol, "speed),<br>methamphetamine (Desoxyn, "crank,<br>crystal, speed, ice")<br>phenmetrazine (Preludin),<br>methylphenidate (Ritalin),<br>phendimetrazine (Prelu-2)<br><br>NARCOTICS:<br>codeine (11 to 90 mg per dosage unit/<br>mixed with aspirin or acetaminophen) |

## Marijuana

| Delivery, Possession with intent to deliver and manufacture | Possession (sect. 333.7403) | Use (sect. 333.7404) | Examples of chemical names, brand names, and/or street names |
|---|---|---|---|
| felony<br>up to 4 years, or<br>fined up to $2000,<br>or both | misdemeanor<br>up to 1 year, or fined<br>up to $1000, or both | misdemeanor<br>up to 90 days/$100<br>or both | hash, hashish, hash<br>oil, sinsemilla |

## Marijuana Without Remuneration

| Any Amounts | Delivery, Possesion with intent to deliver, and manufacture | Possession (Sect. 333.7403) | Use (Sect. 333.7404) |
|---|---|---|---|

## B. THE PUBLIC HEALTH APPROACH

At its very roots, prevention in the field of substance abuse can trace its origins to public health work in disease prevention; some of the language and many of the assumptions of prevention have been borrowed from public health. Public health efforts have achieved many remarkable successes bringing diseases such as typhoid fever and malaria under control, and these successes have often involved changing people's high-risk behavior -- such as eating without washing hands first. Because substance abuse prevention involves behavior change as well, and because chemical dependence is considered a disease, it may be assumed that similar approaches should yield similar success.

Prevention efforts working from traditional public health assumptions have been somewhat successful and many of these efforts continue. It should be kept in mind, however, that the behavioral changes addressed by the most successful public health campaigns have not involved the elements which make drug use and other addictive behaviors special. Specifically, there is a compulsive quality to addictive behaviors; the alcoholic, the heroin addict, and the compulsive gambler all report that they feel that the behavior is almost uncontrollable.

## C. THE EDUCATIONAL APPROACH

A key ingredient in the traditional public health prevention approach has been education. Educating the public about herpes in the late 1970s, for instance, was quite effective in bringing about dramatic changes in the sexual behavior of Americans. In drug abuse prevention as well, education is a key ingredient. There is much that the average person does not know about alcohol and other drugs, and people often make the decision to use a drug without being aware of factors which should be a basis for the decision. There are some adolescents who have been told by a friend that the use of marijuana is not illegal. Many people believe that it is impossible to become alcoholic drinking only beer. Large numbers of people take the drug PCP, even though

they have heard that PCP is a deadly, unpredictable drug, because it is sold under so many different street names they don't realize what they are taking.

At the core of the educational approach, however, is an assumption that information leads to behavior change. This assumption is only partially valid; for some kinds of behavior, the educational approach has proven ineffective. People do sometimes act in ways they know they shouldn't. Furthermore, in the field of drug prevention, a reverse effect can occur when drug information is provided as a way of discouraging drug use; some schools have found that the number of young people trying various drugs *increased* after a drug prevention course was implemented. It appears that for some people the description of drugs and their effects serves to make them more curious.

## D. THE SOCIAL PSYCHOLOGICAL-APPROACH

During World War II the United States government tried to change some of the consumer behavior of its citizens -- for instance, they were encouraged to eat the less attractive cuts of meat to increase the efficiency of meat production and provide more food for soldiers. After trying to make these changes happen through an educational program, and finding little success, the government enlisted the help of social psychologists to analyze the process of behavior change and provide direction for these public efforts. Some dramatic research findings resulted from these government-sponsored projects.

For our purposes here, it is sufficient to note that the research demonstrated how much people affect each other's behavior. Research subjects did things they didn't believe in because others were doing them, and they even reported seeing things which weren't there if enough other people reported seeing them. While a key to changing people's behavior seemed to be changing their underlying beliefs and attitudes, the research showed that the most effective way to make that change was not simply education -- giving them information -- but doing it in such a way that their ***group interaction*** supported the desired changes.

These findings have been utilized within many of the most successful drug prevention programs. Rather than telling people what they should do, these programs combine some basic information about drugs with a

format in which the participants get an opportunity to talk about their feelings, their attitudes, and even their reasons for rejecting the information they have been given. The group leader, guiding the discussions, blends the new information into the conversation and promotes responsible decision-making.

# E. SMOKING PREVENTION -- WHAT WORKS

The most successful, and best-documented, drug prevention programs to date have been ones targeted at reducing smoking. While the overall use of tobacco in the United States has not declined dramatically, it at least has not shown growth matching the population growth. Figures can be confusing because the dramatic decreases in smoking by some parts of the population, especially those in middle adulthood, have been offset somewhat with increases in smoking by other groups, notably young women. It appears that the anti-smoking attitudes developing in the society are being counteracted by changing sex-role attitudes; the increased smoking by young women may represent a rejection of traditional sex-role expectations which held smoking to be inconsistent with femininity.

The most dramatic successes, however, are those documented in communities where primary prevention programs have been implemented in the elementary and junior high schools. The success of these programs is especially significant because tobacco is seen as a "gateway" drug, one which leads to the use of other drugs; by reducing first use of tobacco, these programs may have long-range impact on the use of other drugs. These programs, exemplified by that developed by Botvin (1985) have generally combined the educational approach and the social psychological group approach with some specific elements described below.

## Process of choice and sources of influence

Participants are helped to recognize that they are decision-makers and they learn to recognize the process of decision-making in their lives. They also are given an understanding of the ways in which other individuals, institutions, groups, and communications media may attempt to influence the decision-making process.

### Self-esteem as a basis for individuation

Participants are also taught about the role self-esteem plays in their lives. They learn that they are most vulnerable to others' influence attempts when they feel bad about themselves and are seeking approval. They are given effective approaches which help them become more comfortable with themselves and secure in their relationships with others.

### Social skills

Participants learn how social skills -- the particular ways in which they handle social interactions -- affect their success in dealing with others. While the primary focus is on assertiveness skills, (the ability to say "no" in a convincing way for instance), classes also teach other social skills which can help to build self-esteem and leave one less vulnerable to influence of others.

## F. LIMITATIONS AND FUTURE DIRECTIONS

Prevention of drug abuse is relatively new as a concern of the larger U.S. society; excluding the supply-side efforts to control access and the work of a few religious groups, there is only a brief history of organized prevention efforts. At best, prevention efforts have made small changes in the overall drug-related behavior of the U.S. population. There is still a lot to learn, and some of what seems to have been successful may not look as successful when program effects are followed over a 40-year period. It is also possible that some short-term failures may turn out to be long-range successes. The progress to date has been encouraging.

The most fertile ground for further development of the prevention field is probably in secondary prevention. People who use alcohol and other drugs tend to use denial, a belief that it can't happen to them, as a way to shrug off the concerns of medical professionals, family members, employers, friends, and clergy. Because of this denial, they frequently must reach a point in their lives when serious problems have already

occurred before they realize the effects of the drugs they are using. Once serious problems have brought them to treatment and they become part of the tertiary prevention audience, the denial has been broken to a great extent and they are more likely to be receptive. Getting the attention of the experimental, casual, or social user is among the highest priorities in prevention work for the next few years.

# EXERCISES FOR FURTHER STUDY

1. Call your local school district and ask what prevention activities exist at the elementary, middle, and high school levels. How hard is it to get an answer? Is there someone in the district who is a specialist in prevention?

2. Interview a member of a popular youth group such as Boy or Girl Scouts, Campfire, etc. What is that group doing to (a) directly, and (b) indirectly prevent its members from alcohol and other drug use?

# SUGGESTED READINGS

Alcoholism/Chemical Dependency and the College Student, edited by Timothy Rivinus. This collection of papers is a good picture of the current development of theories and techniques for handling campus substance problems.

Prevention Research: Deterring Drug Abuse Among Children and Adolescents (NIDA Research Monograph #63), edited by Catherine S. Bell and Robert Battjes. A collection of papers from a 1984 conference, this volume critically evaluates both theories and research findings.

"AIDS - Can I Get It?"
Light Video Television, Inc.
21 Highland Circle
Needham Heights, MA 02194

Al-Anon/Alateen Family
Groups World Service Office
PO Box 862
Midtown Station
New York, NY 10018-0862

Alcohol and Drug Abuse Education Program
U.S. Office of Education
400 Maryland Ave., S.W.
Washington, DC 20001

Alcohol and Drug Problems Association of North America (ADPA)
444 North Capitol St., NW
Washington, DC 20001
(202) 737-4340

Alcohol Research Information Services
1120 East Oakland Avenue
Lansing, MI 48906

Alcoholics Anonymous (AA)
Box 459 Grand Central Station
New York, NY 10163
(212) 686-1100

Alliance of American Insurers
1501 Woodfield Road
Schaumburg, IL 60195

American Academy of Pediatrics
1801 Hinman
Evanston, IL 60202

American Automobile Association Foundation for Traffic Safety
8111 Gatehouse Road
Room 209
Falls Church, VA 22047

American Business Men's Research
1208 Michigan National Tower
Lansing, MI 48933



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American College of Emergency Physicians
P.O. Box 317
Highland Springs, VA 23075

American Council on Alcoholism, Inc.
College and University Network
National Executive Offices
8501 LaSalle Road- Suite 301
Towson, MD 20214
(301) 296-5555

American Council on Alcohol Problems Inc.
2908 Patricia Drive
Des Moines, IO 50322

American Council for Drug Education
5820 Hubbard Drive
Rockville, MD 20852

American Driver and Traffic Safety Education Association
123 North Pitt St.
Alexandria, VA 22314

American Medical Association
Safety Education Department
535 North Dearborn St.
Chicago, IL 60610

American Medical Society on Alcoholism
12 West 21st St., 7th Floor
New York, NY 10010

American Red Cross
National headquarters
Youth Services Division
17th and D St.s, NW
Washington, DC 20006

Assoc. of Halfway House Alcoholism Progs of North America (AHHAP)
786 East 7th St.
St. Paul, MN 55106

Assoc. for Medical Education and Research in Substance Abuse (AMERSA)
Brown University Ctr. for Alcohol and Addiction Studies
Box G
Providence, RI 02912

The Application of "Drug-Free Workplace" Law to Institutions of Higher Education
Milton Goldberg's Office
Council on Governmental Relations
One Dupont Circle, Suite 670
Washington, D.C. 200336
(202) 861-2595

BACCHUS (Boost Alcohol Consciousness Concerning the Health of University Students)
Drew Hunter, Exec. Director
P.O. Box 10430
Denver, CO 80210
(303) 871-3068

The Beer Institute
1750 K St., NW
Suite 500
Washington, D.C. 20006

Center for Science in the Public Interest (CSPI)
1501 16th St., NW
Washington, DC 20036
(202) 332-9110

Charlotte Drug Educ. Center
1416 E. Morehead St.
Charlotte, NC 28204

Children of Alcoholics Foundation (COAF)
540 Madison Avenue, 23rd Floor
New York, NY 10022

Citizens Council on Women, Alcohol & Drugs
8293 Main St.
Ellicott City, MD 21043

Clement Communications, Inc.
Concord Industrial Park
Concordville, PA 19331

"Cocaine: A Deadly Elective", $40.00
Health Education Office
204 Brackenridge Hall
University of Pittsburgh
Pittsburgh, PA 15260

Compcare Publications
2415 Annapolis Lane
Minneapolis, MN 55441

Comprehensive Guidelines for an Institutional Response to Alcohol and Other Drug Problems
Elizabeth Broughton, Ed.S.
Campus Alc. & Drug Resource Center
124 Tigert Hall
University of Florida
Gainesville, FL 32611
(904) 392-1261

Council on Alcohol Policy
222 Williamette St.
Berkley, CA 94708

Distilled Spirits Council of the United States, Inc. (DISCUS)
1300 Pennsylvania Building
Washington, DC 20004
(202) 628-3544

DOC (Doctors Ought to Care)
Department of Family Medicine
Medical College of Georgia
Augusta, GA 30912
(404) 721-0211

Drugs and Drug Abuse, A Reference Text, 2nd Ed. $29.50
Marketing Services
Dept. 500
Addiction Research Foundation
33 Russell St.
Toronto, Canada M5S2S1

Drug Enforcement Adm. (DEA)
President's Drug Awareness Campaign
U.S. Department of Justice
Washington, D.C. 20537

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800-COCAINE
Fair Oaks Hospital
19 Prospect St.
Summit, NJ 07901

Employee Assistance
Professionals Association
1800 N. Kent St.
Suite 907
Arlington, VA 22209
(703) 522-6272

Families in Action
3845 North Druid Hills Road
Suite 300
Decatur, GA 30033
(404) 325-5799

"Fraternity Liability" and "Risk Management" VHS Video
($20 each)
Sigma Phi Epsilon
PO Box 1901
Richmond, VA 23215

"Fresh Start: 21 Days to Quit Smoking" $29.95
S & S Video
1230 Avenue of the Americans
New York, NY 10020

Free Radio and Print Ads
Partnership for a Drug Free America
Teresa Quinian
c/o American Association of Advertising Agencies
666 Third Avenue
New York, NY 10017

Freedom from Chemical Dependency Foundation, Inc.
26 Cross St.
Needham, MA 02194
(617) 444-6969

Hazelden Foundation
Box 176
Center City, MN 55012
(612) 257-4010

"Hazing on Trial" $30.00
ATO Fraternity, ATT: Darlene
4001 W. Kirby Avenue
Champaign, IL 61821

Health Education Foundation
Department M - Suite 452
600 New Hampshire Ave., NW
Washington, DC 20037

Highway Users Federation
1766 Massachusetts Ave. NW
Washington, D.C. 20036

Insurance Information Institute
110 Williams St.
New York, NY 10038

International Council on Alcohol & Addiction/American Foundation
P.O. Box 489
Locust Valley, NY 11560

JACS Foundation (Jewish Alcoholics, Chemically Dependent Persons, and Significant Others)
New York Board of Rabbis
10 E. 73rd St.
New York, NY 10021
(212) 737-6261

The Johnson Institute
7151 Metro Blvd.
Edina, MN 55435
(612) 944-0511

The Just Say No Foundation
1777 North California Blvd.
Suite 200
Walnut Creek, CA 94596
800-258-2766

Mothers Against Drunk Driving (MADD)
669 Airport Freeway,#310
Hurst, TX 76053
(817) 268-MADD

Minnesota Prev. Resource Ctr.
2829 Verndale Avenue
Anoka, MN 55303

Multi-Cultural Prev. Work Gp.
Allegheny County MHMR/DA Program
429 Forest Avenue, 9th Floor
Pittsburgh, PA 15219

National Association of Alcoholism and Drug Abuse Counselors (NAADAC)
3717 Columbia Pike, Suite 300
Arlington, VA 22204
(703) 920-4644

National Association of Alcoholism Treatment Programs, Inc. (NAATP)
2082 Michelson Drive
Irvine, CA 92715

National Association for Children of Alcoholics
PO Box 421691
San Francisco, CA 94142
(415) 431-1366

National Association of Gay Alcoholism Professionals
204 W. 20th St.
New York, NY 10011
(212) 807-0634

National Association of Governors' Highway Safety Representatives
444 N. Capitol St. NW
Suite 524
Washington, D.C. 20001

National Association of Secondary School Principals
Division of Student Activities
1904 Association Drive
Reston, VA 22091

National Assn. of State Alcohol and Drug Abuse Directors
444 N. Capital St., N.W.
Suite 520
Washington, DC 20001
(202) 783-6868

National Black Alcoholism Council
417 S. Dearborn St., Suite 700
Chicago, IL 60605
(312) 663-5780

National Child Passenger Safety Association
P.O. Box 841
Ardmore, PA 19003

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National Clearinghouse for Alcohol and Drug Information
P.O. Box 2345
Rockville, Maryland 20852
(301) 468-2600

National Coalition of Hispanic Mental Health and Human Services Organizations
1030 15th St., NW, Suite 1053
Washington, DC 20005
(202) 371-2100

National Collegiate Alcohol Awareness Week
Karen Richardson Karem
2301 South Third St.
203 Administration Blvd.
University of Louisville
Louisville, KY 40292
(502) 588-6933

National Council on Alcoholism and Drug Dependance Inc. (NCADD)
12 West 21st St., 7th Floor
New York, NY 10010
(212) 206-6770

National Federation of Parents for Drug-Free Youth
8730 Georgia Avenue, Ste 200
Silver Springs, MD 20910
(301) 585-5437

National Institute on Alcohol Abuse and Alcoholism (NIAAA)
Parklawn Building
5600 Fishers Lane
Rockville, MD 20852

National Licensed Beverage Association
309 N. Washington St.
Alexandria, VA 20857

National Nurses Society on Addiction
2506 Gross Point Road
Evanston, IL 60201

National Organization of Student Assistance Programs and Professionals (NOSAPP)
250 Arapahoe, Suite 301
Boulder, CO 80320
(800) 972-4636

National Parents' Resource Institute for Drug Education, Inc. (PRIDE)
The Hunt Building, Suite 210
50 Hunt Plaza
Atlanta, GA 30303
(404) 572-4500 or (800) 677-7433

National PTA
Alcohol Education Project
700 North Rush St.
Chicago, Il 60611

National Restaurant Association
311 First St. NW
Washington, D.C. 20001

National Safety Council
444 North Michigan Avenue
Chicago, IL 60601

Operation CORK
A Program of the Kroc
Foundation
8939 Villa La Jolla Dr.
San Diego, CA 92037

The Other Victims of
Alcoholism, Inc. (TOVA)
P.O. Box 921
Radio City Station
New York, NY 10101
(212) 247-8087

Pacific Institute for Research &
Evaluation
JUST SAY NO
7101 Wisconsin Ave., Suite 612
Bethesda, MD 20184

Pharmacists Against Drug
Abuse Foundation
P.O. Box 776
SpringHouse, PA 19477

PRIDE (Parent Resources Insti-
tute on Drug Education)
Robert W. Woodruff Building
100 Edgewood Ave., NE
Suite 1002
Atlanta, GA 30303
800-241-9746

PTA, Alcohol Education Project
700 North Rush St.
Chicago, IL 60611
(312) 787-0977

Reduce Intoxicated Driving
(RID)
P.O. Box 520
Schenectady, NY 12301
(518) 372-9624 or
(518) 372-7196 (if no answer)

Rsch Soc. on Alcoholism (RSA)
U. of Illinois Medical Center
P.O. Box 6998
Chicago, IL 60680

Resources for Responsible
Drinking
Distilled Spirits Council of the
U.S., Inc.
1250 Eye St., N.W. Suite 900
Washington, D.C. 20005
(202) 628-3544

Rutgers University
Center of Alcohol Studies
Penny Page, Librarian
Smithers Hall, Bush Campus
Piscataway, NJ 08854
(201) 932-4442

S.O.S. Peer Facilitator Manual
and S.O.S. Trainer's Manual
$14.00 both
South. Illinois U at Carbondale
S.O.S. Drug Prev. Program
Wellness Center
Carbondale, IL 62901

Students Against Drunk Driving
(SADD)
P.O. Box 800
Marlboro, MA 01752

APPENDIX

Traffic Safety Now, Inc.
Motor Vehicles Manufacturers Assoc.
1620 I St., NW
Washington, D.C. 20006

The U.S. Journal of Drug and Alcohol Dependence
U.S. Journal, Inc.
The Enterprise Center
3201 S.W. 15th St.
Deerfield Beach, FL 33442

U.S. Department of Education
Fund for the Improvement of Post- Secondary Education (FIPSE)
Dr. Ron Bucknam
Drug Prevention Programs in Higher Education
7th & D St. S.W.
Room 3100
Washington, D.C. 20202-5175
(202) 708-9750

U.S. Department of Education
Network of Colleges and Universities Committed to the Elimination of Drug and Alcohol Abuse
Vonnie Veltri, Ph.D.
555 New Jersey Avenue, N.W.
Washington, D.C. 20208
(202) 357-6116

U.S. Govt. Printing Office
Superintendent of Documents
Washington, D.C. 20402

Wisconsin Clearinghouse for Alcohol and Other Drug Information
1954 Washington Ave.
Madison, WI 53704

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